No. 10-2347

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

LIBERTY UNIVERSITY, et al.,

Plaintiffs-Appellants,

v.

TIMOTHY GEITHNER, SECRETARY OF THE TREASURY, et al.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA

BRIEF FOR APPELLEES

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STATEMENT OF JURISDICTION

The district court's jurisdiction arose under 28 U.S.C. §§ 1331 and 1346. The court entered final judgment on November 30, 2010. Plaintiffs filed a notice of appeal on December 1, 2010. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly held that the minimum coverage provision and the employer responsibility provision of the Patient Protection and Affordable Care Act ("Affordable Care Act") are valid exercises of Congress's commerce power.

2. Whether these provisions are also independently authorized by Congress's taxing power.

3. Whether the district court correctly rejected plaintiffs' religion-based objections to the minimum coverage provision.

STATEMENT OF THE CASE

1. The Affordable Care Act is a comprehensive reform of our national health care system. The Act seeks to ameliorate the longstanding crisis in the interstate market for health care services that accounts for more than 17% of the nation's gross domestic product. In enacting the law, Congress found that private health insurance spending was projected to be approximately $854 billion 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." 42 U.S.C.A. § 18091(a)(2)(B).

Increasing numbers of people without health insurance have consumed health care services for which they do not pay. These uncompensated costs — totaling $43 billion in 2008 — are shifted to health care providers that are regularly engaged in interstate commerce. Providers pass on a significant portion of these costs to private insurance companies, which also operate interstate. The result is higher premiums which, in turn, make insurance unaffordable to even greater numbers of people. At the same time, insurance companies use restrictive underwriting practices to deny coverage or charge unaffordable premiums to millions across the nation because they have pre-existing medical conditions.

The Affordable Care Act addresses these national and interstate problems, which individual states are unable to handle comprehensively, through a series of measures that will make affordable health care coverage widely available, protect consumers from restrictive insurance industry underwriting practices, and reduce the uncompensated costs of medical care obtained by the uninsured, which are otherwise borne by others in the health care market.

2. Plaintiffs are two individuals and Liberty University. They challenge the

constitutionality of the minimum coverage provision of the Affordable Care Act, which requires non-exempted individuals to maintain a minimum level of health insurance coverage or pay a tax penalty. 26 U.S.C.A. § 5000A. They also challenge the provision of the Act that imposes a tax assessment on large employers that fail to make adequate coverage available to their full-time employees when at least one of their full-time employees receives a tax credit to assist with the purchase of coverage in a health insurance exchange. *Id*. § 4980H.

The individual plaintiffs do not have health insurance. They acknowledge that they have received and will need health care, but declare that they have made the economic calculation to pay for such services out-of-pocket as they use them. *See* Joint Appendix ("JA") 19 ¶ 34; JA 20 ¶ 38. Plaintiffs contend that the minimum coverage and employer responsibility provisions exceed Congress's Article I powers. They also argue that the minimum coverage provision violates their rights under the religion clauses of the First Amendment, the Fifth Amendment, and the Religious Freedom Restoration Act ("RFRA").

The district court rejected these claims. It upheld the minimum coverage provision and the employer responsibility provision as valid exercises of Congress's commerce power. It rejected the premise of plaintiffs' challenge to the minimum coverage provision – that the provision regulates "inactivity, or 'simply existing.'"

JA 166. Noting the extensive congressional findings regarding the interstate market for health care services and the effect on that market of individual attempts to pay for services without insurance, the court concluded that the conduct regulated by the minimum coverage provision "is economic in nature." JA 170. "Nearly everyone will require health care services at some point in their lifetimes, and it is not always possible to predict when one will be afflicted by illness or injury and require care." *Ibid*. "Regardless of whether one relies on an insurance policy, one's savings, or the backstop of free or reduced-cost emergency room services, one has made a choice regarding the method of payment for the health care services one expects to receive." *Ibid*. "As Congress found, the total incidence of these economic decisions has a substantial impact on the national market for health care by collectively shifting billions of dollars on to other market participants and driving up the prices of insurance policies." JA 170-71.

The court explained that the minimum coverage provision is also instrumental to other reforms in the Affordable Care Act that bar insurance companies from denying coverage because of pre-existing medical conditions (a requirement known as "guaranteed issue") and from charging higher premiums based on a person's medical history (a requirement known as "community rating"). JA 172. "As Congress stated in its findings, the individual coverage provision is 'essential' to this

larger regulatory scheme because without it, individuals would postpone 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." *Ibid*. "This would increase the cost of health insurance and decrease the number of insured individuals — precisely the harms that Congress sought to address with the Act's regulatory measures." *Ibid*.

Turning to the employer responsibility provision, the court emphasized that "it is well-established in Supreme Court precedent that Congress has the power to regulate the terms and conditions of employment." JA 173. The court held that Congress had a rational basis to conclude that "the terms of health coverage offered by employers to their employees have substantial effects cumulatively on interstate commerce." JA 174.

The court also rejected plaintiffs' religion-based challenges, JA 177-90, and entered judgment for the government.[1]

STATEMENT OF FACTS

In the Affordable Care Act, Congress made detailed findings addressed to the standards that have been established by the Supreme Court for assessing whether

[1] The government does not challenge the district court's threshold determinations on standing, ripeness, and the applicability of the Anti-Injunction Act.

Congress has acted within its Commerce Clause power. Congress found that the Act's minimum coverage requirement regulates "economic and financial decisions about how and when health care is paid for," 42 U.S.C.A. § 18091(a)(2)(A); that health insurance "is sold in interstate commerce and claims payments flow through interstate commerce," *id*. § 18091(a)(2)(B); that the consumption of health care without insurance has substantial adverse effects on the interstate health care market, *id*. § 18091(a)(2)(F); and that the minimum coverage requirement is "essential" to the Act's insurance reforms that prevent insurers from denying coverage or charging higher premiums because of an individual's medical condition or history, *id*. § 18091(a)(2)(I).

I. Background

A. The interstate market for health care services differs from other markets in critical respects.

In responding to the crisis in the interstate health care market, Congress confronted a market that is different in critical respects from any other. Spending in the interstate health care market is extraordinary, accounting for 17.6% of the nation's gross domestic product in 2009. Centers for Medicare & Medicaid Services ("CMS"), National Health Expenditure 2009 Highlights, at 1 (2011). Participation is essentially universal; an individual's need for expensive medical care is unpredictable; and,

across the nation, emergency care is routinely provided without regard to an individual's ability to pay. The market is also unique in that individuals typically pay for health care services through private or government insurance.

Although most people obtain health care services on an ongoing basis, they cannot accurately predict their future need for such services. "Most medical expenses for people under 65" result "from the bolt-from-the-blue event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." Expanding Consumer Choice and Addressing "Adverse Selection" Concerns in Health Insurance, Hearing Before the Joint Economic Comm. 32 (2004) (Prof. Pauly). Costs mount rapidly for treatment of even the most common significant health problems. For example, the average cost of an appendectomy in 2010 was $13,123. International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees By Country, at 14. The average cost of a day in the hospital was $3,612; of a hospital stay, $14,427; of a Caesarian-section, $13,016; of bypass surgery, $59,770; of an angioplasty, $29,055. *Id.* at 9, 10, 12, 16, 17. Drug treatment for a common form of cancer costs more than $150,000 a year. Meropol et al., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007). Thus, although the potential for financially ruinous burdens is plain, what actually will happen — the "frequency, timing, and magnitude"

of an individual's demand for health care services — is unknowable. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007).

Another distinction between the interstate health care market and other markets is that many individuals receive, and expect to receive, costly health care services in times of need without regard to their ability to pay. For 25 years, the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") has required hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, regardless of whether the person has insurance or otherwise can pay. 42 U.S.C. § 1395dd. Even before enactment of EMTALA, many state legislatures and courts had recognized that hospitals cannot properly turn away people in need of emergency treatment.

B. Insurance is the principal means used to pay for health care services, and the federal government's involvement in this system of health care financing is pervasive.

Reflecting the special characteristics of the national health care market, payment for health care services is usually made through insurance. In 2009, payments by private health insurers constituted 32% of the $2.5 trillion in national health care spending. CMS, 2009 National Health Expenditure Data, table 3 (2011). Employment-based insurance plans accounted for most private coverage; about 59% of the non-elderly U.S. population (156.2 million people) had employer-based health

insurance in 2009. Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). In that year, about 5.2% of the non-elderly population (13.8 million people) had policies purchased in the individual insurance market. *Ibid.*

In 2009, more than 43% of health care spending was financed by federal, state, and local governments. CMS, 2009 National Health Expenditure Data, tables 5 & 11. The federal government provides health insurance for older and disabled Americans under Medicare, accounting for 20% of national health care spending in 2009. *Id*., table 11. Federal and state governments provide health insurance for low-income Americans through Medicaid, which constituted an additional 15% of national health care spending in 2009. *Ibid*. Another 12% of health care spending reflected government spending on benefits for veterans and their dependents; workers' compensation; and the Children's Health Insurance Program for limited-income children. *Id*., table 5.

As these figures indicate, the federal government's involvement in the system of health care financing is pervasive. In 2009, federal spending on Medicare and Medicaid was around $750 billion; billions more went to other federal programs, such as programs for veterans. Congressional Budget Office ("CBO"), The Long-Term Budget Outlook, at 30 (2010). These figures do not include the federal government's

longstanding use of tax incentives to finance health care costs. CBO, Key Issues In Analyzing Major Health Proposals, at 30 (2008) ("Key Issues").[2]

C. People who endeavor to pay for health care services through means other than insurance, as a class, shift significant economic costs to other participants in the interstate health care market.

An estimated 18.8% of the non-elderly population (approximately 50 million people) had no health insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8. People without insurance are active participants in the interstate health care market, consuming over $100 billion of health care services annually. Families USA, Hidden Health Tax: Americans Pay a Premium, at 2 (2009) ($116 billion in 2008); *see also*, *e.g.*, CDC, National Center for Health Statistics, Health, United States, 2009, at 318 table 80 (2010) (80% of those without insurance at some point during a 12-month period made at least one visit to a doctor or emergency room); CDC, National Center for Health Statistics, Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?, at 2 (2010) (20% of uninsured adults aged 18-44 visited the emergency room at least once in 2007); CDC, National Center for Health Statistics, Summary Health Statistics Health Statistics for U.S. Children: National Health

[2] The federal government is involved in other aspects of health care, including the regulation of drugs and medical devices, 21 U.S.C. §§ 301, 351, and dealing with diseases that cross state boundaries. 42 U.S.C. § 264(b) (federal quarantine statute).

Interview Survey, 2009, table 16 (2010) (18% of uninsured children visited the emergency room at least once in 2009).

People without insurance, as a group, do not pay the full cost of the services they obtain and "receive treatments from traditional providers for which they either do not pay or pay very little." CBO, Key Issues, at 13. Congress found that, in 2008, the cost of providing uncompensated health care to the uninsured — *i.e.*, care not paid for by the patient or a third party — was $43 billion. 42 U.S.C.A. § 18091(a)(2)(F); *see also* Families USA, Hidden Health Tax at 2, 6. Congress further found that health care providers pass on a significant portion of these costs "to private insurers, which pass on the cost to families," increasing the average premiums paid by families who carry insurance by "over $1,000 a year." 42 U.S.C.A. § 18091(a)(2)(F); *see also* Families USA, Hidden Health Tax at 2, 6.

D. Before passage of the Affordable Care Act, the percentage of non-elderly people in the United States with private health insurance steadily decreased due to rising premiums and barriers to obtaining coverage.

In 2009, the percentage of the non-elderly with private health insurance coverage (64.2%) was significantly lower than in 2000 (73.4%), meaning that millions more Americans lacked insurance. Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). The percentage covered by

employment-based plans, traditionally the largest source of private health insurance, declined from 68.3% in 2000 to 59% in 2009. *Ibid*.

People who attempt to purchase health insurance in the individual insurance market face significant obstacles. Insurers scrutinize the medical condition and history of applicants to determine eligibility and premiums, a process known as "medical underwriting." CBO, Key Issues at 8, 80. A recent national survey estimated that 12.6 million non-elderly adults — 36% of those who tried to purchase health insurance in the previous three years in the individual insurance market — were denied coverage, charged a higher rate, or offered limited coverage because of a pre-existing condition. Department of Health and Human Services ("HHS"), Coverage Denied: How the Current Health Insurance System Leaves Millions Behind (2009).

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

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

II. The Affordable Care Act

The Affordable Care Act addressed the problems in the national health care system, which states are unable to solve individually. Through a series of measures, the Act will make health care coverage widely available and affordable, protect consumers from insurance industry underwriting practices, and reduce the uncompensated care that shifts costs to other participants in the interstate health care market and increases the premiums paid by insured consumers. In so doing, the Act removes obstacles to interstate commerce, such as the reluctance of workers to take new jobs for fear of becoming unable to obtain affordable insurance.

First, the Act builds upon the existing nationwide system of employer-based health insurance that is the principal private mechanism for health care financing. Congress established tax incentives for small businesses to purchase health insurance for their employees. 26 U.S.C.A. § 45R. And, in the employer responsibility provision at issue here, Congress prescribed tax penalties for a large employer if it does not offer full-time employees adequate coverage, and at least one full-time employee receives a tax credit to assist with the purchase of coverage in a health insurance exchange established under the Act. *Id*. § 4980H.

Second, the Act creates health insurance exchanges to allow individuals, families, and small businesses to use the leverage of collective buying power to obtain

prices and benefits competitive with those of typical employer group plans. 42 U.S.C.A. § 18031.

Third, for eligible individuals and families with household income between 133% and 400% of the federal poverty line who purchase coverage through an exchange, Congress created federal tax credits for payment of health insurance premiums. 26 U.S.C.A. § 36B(a)-(c). Congress also created cost-sharing reductions to help cover out-of-pocket expenses such as copayments or deductibles for eligible individuals who receive coverage in an exchange. 42 U.S.C.A. § 18081. Congress also expanded eligibility for Medicaid to all individuals with income below 133% of the federal poverty line. *Id*. § 1396a(a)(10)(A)(i)(VIII).

Fourth, the Act imposes new regulations on insurance companies to protect individuals from industry practices that have prevented people from obtaining and keeping health insurance. The Act bars insurance companies from refusing coverage because of pre-existing medical conditions, canceling insurance absent fraud or intentional misrepresentation of material fact, charging higher premiums based on a person's medical history, and placing lifetime caps on benefits the policyholder can receive. *Id.* § 300gg-1(a), -3(a), -11, -12.

Fifth, in the minimum coverage provision at issue here, the Act requires that non-exempted individuals pay a tax penalty if they do not maintain a minimum level

of health insurance. 26 U.S.C.A. § 5000A.[3] The penalty does not apply to individuals with insufficient household income to be required to file a federal tax return, whose share of premium payments exceeds 8% of their household income, or who establish that the requirement imposes a hardship. *Id.* § 5000A(e).

Congress exempted members of "health care sharing ministries" who do not participate in the general health care market, *id.* § 5000A(d)(2)(B), as well as adherents of religious sects that are "conscientiously opposed to acceptance of the benefits of any private or public insurance," provided the sect makes "provision for their dependent members" and meets other requirements, *id.* § 5000A(d)(2)(A).

The CBO projected that the Act would reduce the number of non-elderly people without insurance by about 32 million by 2019. Letter from Douglas W. Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, U.S. House of Representatives, at 9 (Mar. 20, 2010).

[3] This insurance requirement may be satisfied through enrollment in an employer-sponsored insurance plan; an individual market plan including a plan offered through a health insurance exchange; a grandfathered health plan; a government-sponsored program, such as Medicare, Medicaid, or TRICARE; or similar coverage recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. 26 U.S.C.A. § 5000A(f).

SUMMARY OF ARGUMENT

The Affordable Care Act as a whole, and the minimum coverage and employer responsibility provisions in particular, regulate the diverse methods by which consumers pay for health care services in the massive interstate health care market. The Act reflects the considered effort of the elected branches of government — based on months of debate, weeks of hearings, and detailed empirical studies — to stem a crisis in the health care market that has threatened the vitality of the U.S. economy.

I. A. The Constitution grants Congress the power to regulate conduct that substantially affects interstate commerce. As Congress found, payment for services in the interstate health care market is economic activity that substantially affects interstate commerce. The requirement that participants in the health care market have insurance to pay for the services they consume is thus a quintessential exercise of the commerce power. The regulation furthers two principal economic goals. First, it prevents the substantial cost-shifting in the interstate health care services market that results from the practice of consuming health care without insurance. Second, it is key to the viability of the Act's requirement that insurers cannot deny coverage or charge higher premiums because of an individual's medical condition or history.

Fundamental features of the legislation and the health care market are in dispute. Health care providers and insurers operate interstate. Virtually all

Americans, including the individual plaintiffs, participate in the health care market. The need for expensive health care services is unpredictable, and people who endeavor to pay for such services without insurance do not, as a class, pay the full cost of the services they obtain.

The federal government, along with state governments, shoulders some of these costs. Health care providers pass much of the remainder on to private insurers, which pass it on to their customers. Rising premiums contribute in turn to the decline in the population covered by private insurance. Completing the cycle, the growing percentage of people without health insurance further inflates premiums.

The Affordable Care Act seeks to break this cycle by requiring consumers to maintain a minimum level of insurance to meet health care costs. The Act also restricts the medical underwriting practices that have precluded many Americans from obtaining affordable insurance because of pre-existing medical conditions. The statute thus makes persons such as the individual plaintiffs legally insurable regardless of past, present, or future illness or injury, and protects them from higher premiums based on medical condition or history. The experience of state insurance regulators demonstrated that such a system of guaranteed issue and community rating is unworkable if health care consumers can postpone the purchase of insurance until their medical costs outstrip their insurance premiums.

In sum, the minimum coverage provision is within the commerce power because it is a wholly rational means of regulating payment for health care services by participants in the health care market, of preventing consumers from shifting costs to other market participants, and of effectuating the requirements of guaranteed coverage and community rating. *Gonzales v. Raich*, 545 U.S. 1, 16-17, 22 (2005).

B. The Supreme Court has repeatedly emphasized that courts must accord great deference to the regulatory means Congress selects to accomplish its legitimate regulatory objectives, a deference that reflects the constitutional authority and institutional capacity of the political branches to make such operational choices. Thus, Congress's power can even extend to regulation of an "*intrastate* activity" or even *"noneconomic local* activity" — "the relevant question is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment). That standard echoes the principles set forth by Chief Justice Marshall in *McCulloch v. Maryland*, 17 U.S. 316, 421 (1819): "Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional."

The end that Congress seeks to address is undoubtedly legitimate because

consumption of health care services without insurance has demonstrable and harmful effects on other participants in the interstate health care market. The means that Congress adopted are proper and are adapted to the unique conditions of the national market for health care services. Participation in the market is nearly universal, and, in contrast to other markets with widespread participation, consumers cannot predict the timing and the extent of their need for expensive health care services. When that need arises, individuals depend on the extensive medical infrastructure financed and sustained by other participants in the health care services market to provide services. The cost of those services can easily exceed the consumer's ability to pay and, unlike in other markets, consumers can and do receive expensive forms of medical treatment in times of need for which they do not pay. Congress had far more than a rational basis to conclude that consumption of health care services without insurance substantially affects interstate commerce, and that a minimum coverage requirement will restrict the shifting of costs to other market participants and be instrumental in effectuating a comprehensive regulatory scheme.

C. The individual plaintiffs acknowledge that they participate in the market for health care services. They argue, however, that because they have not purchased insurance, the minimum coverage provision regulates their "inactivity in commerce," which they describe as "a decision not to purchase health insurance and to otherwise

privately manage" their health care. Pl. Br. 1.

This argument misconceives the nature of the regulated market as well as the governing Commerce Clause principles. Persons who attempt to pay for health care services out-of-pocket are no more "inactiv[e] in commerce" than persons who pay with insurance. The requirement to maintain insurance is inextricably bound up with the regulation of the health care market, of which health insurance is an integral component. Plaintiffs' effort to divorce their active participation in the health care market from their means of payment for services in that market disregards the teachings of the Supreme Court, which has rejected such artificial distinctions in favor of "broad principles of economic practicality." *United States v. Lopez*, 514 U.S. 549, 568-75 (1995) (Kennedy, J., concurring).

The decisions that plaintiffs invoke were concerned with preserving "a distinction between what is truly national and what is truly local." *United States v. Morrison*, 529 U.S. 598, 617-618 (2000) (quoting *Lopez*, 514 U.S. at 567-568). But plaintiffs do not and could not suggest that regulation of the interstate health care market and the health insurance market — which have long been subject to federal regulation — intrudes upon a domain reserved exclusively to the states. The modern health care system operates across state boundaries. Most health insurance is sold or administered by national or regional companies that operate interstate, and pays for

medical supplies shipped in interstate commerce. Further, "hospitals are regularly engaged in interstate commerce, performing services for out of state patients and generating revenues from out of state sources." *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 213 (4th Cir. 2002). Unlike the statutes in *Lopez* and *Morrison*, the Affordable Care Act regulates interstate activity that is truly national and inherently economic. Moreover, the Act addresses concerns that states may have difficulty addressing individually. Unless medical underwriting is regulated on a national basis, for example, the prospect of losing employee insurance benefits may trap individuals in their current job and state, obstructing the very mobility that the commerce power was designed to protect.

At bottom, plaintiffs' rhetoric does not concern the limits of the Commerce Clause, but rather the scope of governmental authority generally, whether state or federal. In the guise of a commerce power argument, they assert an infringement of their freedom of contract. Such economic due process claims, however, have not succeeded since the *Lochner*-era and have no merit here.

II. If the Court were to reach the issue, the minimum coverage and employer responsibility provisions also may be upheld as valid exercises of Congress's taxing power. In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words

which may be applied to it." *Nelson v. Sears, Roebuck & Co*., 312 U.S. 359, 363 (1941). The provisions appear in the Internal Revenue Code and operate as taxes. They are projected to raise billions of dollars in revenue each year once fully in effect. The validity of the assessments does not turn on whether they are labeled as "taxes." Indeed, the Constitution uses several different terms to refer to the concept of taxation.

III. Plaintiffs' religion-based objections are insubstantial for the reasons set out by the district court.

STANDARD OF REVIEW

This Court reviews *de novo* a district court's decision to grant a motion to dismiss. *Novell, Inc. v. Microsoft Corp.*, 505 F.3d 302, 307 (4th Cir. 2007).

ARGUMENT

I. The Minimum Coverage Provision and Employer Responsibility Provision Are Valid Exercises of Congress's Commerce Power.

The Constitution grants Congress power to "regulate Commerce ... among the several States," U.S. Const., art. I, § 8, cl. 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id*. cl. 18. This grant of authority allows Congress to regulate not only interstate commerce but also to address other conduct that "substantially affect[s] interstate commerce." *Raich*, 545 U.S. at 16-17. In assessing those substantial effects, Congress's focus is necessarily broad. Congress may consider the aggregate effect of a particular form of conduct of those

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

In reviewing the validity of legislation enacted under the commerce power, a court's task "is a modest one." *Ibid.* The court "need not determine" whether the regulated conduct, "taken in the aggregate, substantially affect[s] interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *United States v. Gould*, 568 F.3d 459, 472 (4th Cir. 2009) (quoting *Raich,* 545 U.S. at 22). A court is similarly deferential in reviewing the means Congress chooses to achieve legitimate ends. "[T]he Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch*, 17 U.S. at 413, 418). This deference reflects both separation-of-powers principles and Congress's superior capacity to make empirical and operational judgments. It "has special significance in cases, like this one, involving congressional judgments concerning regulatory schemes of inherent complexity." *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180, 196 (1997).

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

Congress's findings and the legislative record leave no doubt that the minimum coverage provision — which regulates the means of payment for services in the interstate health care market — "regulates activity that is commercial and economic in nature," 42 U.S.C.A. § 18091(a)(2)(A), and that has an enormous impact on interstate commerce. First, the minimum coverage provision addresses the consumption of health care services without payment, which is indisputably activity that shifts billions of dollars of costs annually to other participants in the interstate health care market and to the federal government and states. *Id*. § 18091(a)(2)(F). These costs are spread across state lines because many insurance companies operate in multiple states. *Id*. § 18091(a)(2)(B). Second, the provision is instrumental to the viability of the statute's regulation of medical underwriting, which guarantees persons such as plaintiffs that they will be insurable regardless of illnesses or accidents, and will not be charged higher premiums on account of health status or history. *Id*. § 18091(a)(2)(I), (J).

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

The interstate nature of the market for health care services is not in dispute. Nor is it controverted that, as a class, Americans participate in the market for health care services whether or not they have health insurance. *See* pp.10-11, *supra*. The uninsured population does not, however, bear the full cost of this participation. A 2005 study found that, even in households at or above median income, uninsured people on average pay for less than half the cost of the medical care they consume. Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. Health Econ. 225, 229-30 (2005).

Congress made statutory findings that quantified this impact on interstate commerce: "The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008." 42 U.S.C.A. § 18091(a)(2)(F). Congress also provided further detail on how these costs affect the interstate health care market — costs are passed on from providers "to private insurers, which pass on the cost to families." *Ibid.*

Congress determined that this cost-shifting inflates premiums that families pay for their health insurance "by an average of over $1,000 a year." *Ibid.*; *see also* 156 Cong. Rec. E506-01, 2010 WL 1133757 (Rep. Waxman) (Mar. 25, 2010). In

California, for example, an estimated 10% of health insurance premiums is attributable to uncompensated care consumed by people without insurance. S. Rep. No. 111-89, at 2 (2009).

Supreme Court precedents make clear that it is irrelevant whether a particular individual's consumption of health care services without insurance will impose a substantial burden on the interstate health care market, because it is the aggregate impact that justifies the exercise of the commerce power. *Raich*, 545 U.S. at 18-19; *Wickard v. Filburn*, 317 U.S. 111, 127 (1942). Nor does the commerce power require a showing that every uninsured person will shift health care costs. Millions will do so each year, and the cumulative impact of such cost-shifting is a multi-billion dollar annual burden on interstate commerce — a burden that easily qualifies as "substantial." Congress is not required "to legislate with scientific exactitude," *Raich*, 545 U.S. at 17, and does not have to predict, person-by-person, who among the uninsured will receive medical services and fail to pay in a given year. The Court has repeatedly held that where "Congress decides that the 'total incidence' of a practice" — here, the practice of consuming health care services without insurance — "poses a threat to a national market, it may regulate the entire class." *Ibid*. (quoting *Perez v. United States*, 402 U.S. 146, 154-155 (1971)); *see also Gould*, 568 F.3d at 474-75.

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

The minimum coverage provision is also valid Commerce Clause legislation because it is an integral part of the broader statutory scheme, which requires that insurers extend coverage and set premiums without regard to pre-existing medical conditions. These provisions thus make persons such as the individual plaintiffs insurable even if they currently have, previously had, or will develop medical conditions.

Learning from the experience of state regulators, Congress recognized that an effective system of guaranteed issue and community rating is unsustainable if participants in the health care market can postpone purchasing insurance until an acute need arises. Accordingly, Congress concluded that the absence of a minimum coverage requirement "would leave a gaping hole" in the regulatory scheme. *Raich*, 545 U.S. at 22. Thus, even if the means of payment for health care services were not regarded as economic, it would nevertheless properly be regulated because Congress found that the "failure to regulate that class of activity would undercut the regulation of the interstate market." *Id*. at 18; *see also id*. at 37-38 (Scalia, J., concurring in the judgment) (noting that, in *United States v. Darby*, 312 U.S. 100 (1941), the Court upheld employer record-keeping requirements for intrastate transactions as an appropriate means to ensure compliance with its regulation of interstate commerce);

Hoffman v. Hunt, 126 F.3d 575, 587 (4th Cir. 1997) (Congress could restrict efforts to obstruct access to reproductive health care facilities because the regulated activity "while not itself economic or commercial, is closely and directly connected with an economic activity").

The nation faces an acute shortage of affordable health insurance. More than 50 million Americans went without insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8. Many of these people were priced out of the market by rising premiums. Between 1999 and 2010, for example, average premiums for employer-sponsored family coverage increased 138 percent. Kaiser Family Foundation Employer Health Benefits, 2010 Annual Survey at 31, table 1.11 (2010).

Many others are excluded as a result of a screening process known as "medical underwriting," in which coverage eligibility and premium levels are established based on individual health status or history. About 36% of non-elderly adult applicants in the individual market are denied coverage, charged a substantially higher premium, or offered limited coverage because of pre-existing conditions. Coverage Denied, *supra*, at 1. Depending on the definition used, between 50 and 129 million non-elderly Americans (or 19 to 50% of the non-elderly population) have at least one pre-existing condition, and more than 600,000 individuals were excluded by the

the four largest for-profit insurers in the three years before the Affordable Care Act was enacted. HHS, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans (2011); Chairman Henry A. Waxman and Rep. Bart Stupak, Memorandum on Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market to H. Comm. on Energy and Commerce, at 1 (Oct. 12, 2010).

Insurers often deny coverage even for minor pre-existing conditions. "In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage." 47 Million and Counting, Hearing Before the S. Comm. on Finance, 110th Cong. 52 (2008) (Prof. Hall); *see* Consumer Choices and Transparency in the Health Insurance Industry, Hearing Before the S. Comm. on Commerce, Science and Transp., 111th Cong. 29 (2009). "The four largest for-profit health insurance companies ... have each listed pregnancy as a medical condition that would result in an automatic denial of individual health insurance coverage." Chairman Waxman and Rep. Stupak, Memorandum on Maternity Coverage in the Individual Health Insurance Market to H. Comm. on Energy and Commerce, at 1 (Oct. 12, 2010).

The Act addresses these restrictive underwriting practices by barring insurance companies from denying coverage or setting premiums based on medical condition. Congress found that these guaranteed-issue and community-rating requirements would

not work without a minimum coverage provision to prevent health care consumers from waiting to buy insurance until they are sick or injured. 42 U.S.C.A. § 18091(a)(2)(I). A "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." 47 Million and Counting, 110th Cong. 52 (Prof. Hall). Congress thus found the provision "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." 42 U.S.C.A. § 18091(a)(2)(J).

The legislative record demonstrated that the absence of a minimum coverage requirement linked to guaranteed-issue and community-rating measures had undermined health care reform efforts in several states. Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Health, 111th Cong. 11 (Mar. 17, 2009) (Prof. Reinhardt). Citing New Jersey's experience, Reinhardt explained that "[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." *Ibid.*; *see also* Monheit et al., *Community Rating & Sustainable Individual Health Insurance Markets in New Jersey*, 23 Health Affairs 167, 168 (2004).

In the wake of similar legislation in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Hall, *An Evaluation of*

New York's Reform Law, 25 J. Health Politics, Pol'y & Law 71, 91-92 (2000). And when Maine enacted similar legislation, most insurers withdrew from the state. Health Reform in the 21st Century: Insurance Market Reforms, Hearing Before the H. Comm. on Ways and Means, 111th Cong. 117 (2009) (Letter of Phil Caper, M.D., and Joe Lendvai).

In contrast, Congress found that Massachusetts avoided these perils by enacting a minimum coverage requirement as part of its broader insurance reforms. That requirement "has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased." 42 U.S.C.A. § 18091(a)(2)(D).

The massive legislative record thus supports Congress's finding that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id*. § 18091(a)(2)(I). Congress is plainly permitted to enact a provision so integral to its insurance reforms.

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

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

Plaintiffs do not dispute that people who obtain health care services without insurance shift substantial costs to other market participants; nor do they dispute the centrality of the minimum coverage provision to the Affordable Care Act's broader regulation of medical underwriting. Plaintiffs instead challenge the means by which Congress determined to regulate payment in the interstate market for health care services. Governing precedent leaves no room for plaintiffs' invitation to override Congress's judgment about the appropriate means to achieve its legitimate objectives.

"[T]he Federal '[g]overnment is acknowledged by all to be one of enumerated powers,'" but, "at the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 405, 408). Justice Scalia invoked this time-honored precept when he observed that the "regulation of an intrastate activity may be essential to a comprehensive regulation of interstate commerce even though the intrastate activity does not itself 'substantially affect' interstate commerce." *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment). "Moreover, as ... *Lopez* ... suggests, Congress may regulate even noneconomic local activity if that regulation is

a necessary part of a more general regulation of interstate commerce." *Ibid*. (citing *Lopez*, 514 U.S. at 561). Where "Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Id*. at 36 (quoting *United States v. Wrightwood Dairy Co*., 315 U.S. 110, 118-19 (1942)).

Thus, "the relevant inquiry" under the Necessary and Proper Clause "is simply 'whether the means chosen are "reasonably adapted" to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S. Ct. at 1957 (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment) (quoting *Darby*, 312 U.S. at 121)). Accordingly, "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute," the Court asks "whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Id*. at 1956.

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

The means chosen by Congress to effectuate the Affordable Care Act's regulatory goals were dictated by, and tailored to, the unique features of the market for health care services: participation is essentially universal; the need for medical treatment may arise unexpectedly and not as a matter of choice; the cost of care may

overwhelm the typical family budget; and, in many cases, an individual can expect to receive expensive medical services without regard to his ability to pay.

A government requirement to purchase insurance to avoid the externalization of costs is hardly novel. In the case of vehicle insurance, the requirement may accompany registration of an automobile. The risks addressed by health insurance, however, are always present and are not linked to a particular circumstance such as car ownership. Moreover, our society has long recognized that some forms of medical treatment are not privileges conditioned on compliance with regulations. While it is entirely acceptable for the government to make automobile insurance a condition for use of the highways, it would be entirely unacceptable to impose a comparable requirement on the use of an emergency room.

Even before enactment of the EMTALA in 1986, state courts and legislatures had responded to the changing role of private hospitals and of emergency rooms by creating tort liability for the failure to provide emergency services. The common law had long recognized limitations on a physician's ability to abandon treatment regardless of patients' ability to pay, but recognized no duty on the part of private physicians to provide care in the first place. *Becker v. Janinski*, 15 N.Y.S. 675 (N.Y. Sup. 1891). The common law evolved, however, to preclude hospitals from turning away patients with emergency needs because they are unable to pay for services.

Thus, the Delaware Supreme Court held in 1961 that "liability on the part of a hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency." *Wilmington General Hospital v. Manlove,* 174 A.2d 135, 140 (Del. 1961); *see also Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) ("modern rule" is "that liability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency"). In addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists[.]" H.R. Rep. No. 99-241(III) (1985), at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 727.

These measures were inadequate, however, to prevent "hospital emergency rooms [from] refusing to treat patients with emergency conditions if the patient does not have medical insurance.'" H.R. Rep. No. 99-241(I), at 27 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 605). Congress thus enacted EMTALA "to address a growing concern with preventing 'patient dumping,' the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions were stabilized." *Vickers v. Nash General Hospital*, 78 F.3d 139, 142 (4th Cir. 1996). The federal statute augmented state law by requiring all

hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, without regard to ability to pay. 42 U.S.C. § 1395dd; *see also Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (per curiam).

The minimum coverage provision is adapted to these practical and moral imperatives. It is clearly "proper" for Congress to take into account both the practical realities of the health insurance market and the societal judgment — reflected in the common law as well as EMTALA — that it is unconscionable to deny medical care to someone in an emergency because of the economic choices that she has made. *Cf. Comstock*, 130 S. Ct. at 1961 (noting "common law" requirements imposed on custodians when holding it "necessary and proper" for Congress to confine a federal prisoner whose mental illness threatens others).

3. Plaintiffs, like virtually all other Americans, participate in the health care market whether or not they currently purchase health insurance.

a. Plaintiffs' Statement of Issues — "Whether Congress has authority under the Commerce Clause to regulate a private citizen's inactivity in commerce (a decision not to purchase health insurance and to otherwise privately manage her own healthcare) and force said citizen to participate in commerce," Pl. Br. 1 — underscores the fundamental error in their position. Plaintiffs are not "inactiv[e] in commerce." Like

virtually all Americans, they participate in the commercial market for health care services. JA 19 ¶ 34 (alleging that Waddell "receives the health care services she needs and desires and pays for them as she uses them"). The minimum coverage provision regulates how they pay for services in that market — activity that is itself "commercial and economic in nature" and a subject of interstate commerce. 42 U.S.C.A. § 18091(a)(2)(A).

Plaintiffs' contention that they are not market participants echoes arguments rejected by the Supreme Court. In *Raich*, the Court upheld the application of the Controlled Substances Act to the possession of marijuana that was grown at home for personal use. The Court found it irrelevant that the individuals were not engaged in commercial activity and did not buy, sell, or distribute any portion of the marijuana they possessed. The regulation was proper, the Court held, because "Congress had a rational basis for concluding that leaving home-consumed marijuana outside federal control would . . . affect price and market conditions." *Raich*, 545 U.S. at 19. The failure to regulate such consumption would, in the aggregate, have a "substantial effect on supply and demand in the national market for that commodity." *Ibid.*

Raich reflected principles established more than half a century earlier in *Wickard v. Filburn*, 317 U.S. 111 (1942), which upheld federal regulation of wheat grown and consumed on a family farm as part of a program to control the volume and

price of wheat moving in interstate commerce. The Court sustained that exercise of the commerce power even though the wheat at issue was not "sold or intended to be sold," *id*. at 119, even though the home consumption of wheat by any individual "may be trivial by itself," *id*. at 127, and even though the regulation "forc[ed] some farmers into the market to buy what they could provide for themselves," *id.* at 129.

b. Plaintiffs acknowledge that they participate in the commercial market for health care services. They urge, however, that they do not participate in the insurance market and have elected instead to "save for and privately manage their health care." Pl. Br. 10. As the district court observed, "Plaintiffs' preference for paying for health care needs out of pocket rather than purchasing insurance on the market is much like the preference of the plaintiff farmer in *Wickard* for fulfilling his demand for wheat by growing his own rather than by purchasing it." JA 171.

As in *Wickard*, permitting plaintiffs to exercise their preference would undermine the federal scheme for regulating the health care market in which they participate. Medical expenses can accumulate rapidly and without warning, and plaintiffs, for example, do not suggest that they have the funds needed to cover the full cost of a significant medical expense. As noted, when people who decline to maintain health insurance encounter unexpected expenses for which they cannot pay, those costs are borne by other consumers who *do* purchase insurance. This multi-billion

dollar burden substantially affects the interstate health care services market.

Contrary to plaintiffs' premise, Congress was not required to consider the health insurance market in isolation, divorced from its integral relationship to the overall health care services market. Congress did not establish the minimum coverage provision as an *end;* rather it was imposed as a means toward proper financing of, and expanded access to, health care services and of preventing market participants from externalizing their costs. Congress is regulating the conduct of participants in the health care market, which is permissible even if the regulated participants are inactive in the insurance market. Thus, even assuming *arguendo* that the minimum coverage provision could be thought to regulate inactivity, Congress is not regulating inactivity "as such," *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment), but as an aspect of its regulation of participation in the health care market.

Plaintiffs' attempt to draw an impermeable line separating the purchase of health care services from the maintenance of insurance coverage to pay for them ignores the fundamental characteristic of health insurance — its function as the principal means of payment for health care services in the United States. Buying insurance reflects a choice of one method of dealing with the cost of potential medical expenses, in preference to other options. Porat et al., *Market Insurance versus Self Insurance*, 58 J. Risk & Ins. 657, 668 (1991). Those who resort to those other options

may "use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services." Ruger, *supra*, 100 Q.J. Med. at 55. Implicitly or otherwise, these actions commonly reflect economic assessments of the relevant advantages of obtaining insurance versus other means of attempting to pay for health care services, although those assessments often ignore or underestimate the risks. Pauly, *Risks and Benefits in Health Care: The View From Economics*, 26 Health Affairs 653, 658 (2007).

One way or another, those who participate in the health care market must determine whether and how they will pay for the services they receive. "Regardless of whether one relies on an insurance policy, one's savings, or the backstop of free or reduced-cost emergency room services, one has made a choice regarding the method of payment for the health care services one expects to receive." JA 170. "As Congress found, the total incidence of these economic decisions has a substantial impact on the national market for health care by collectively shifting billions of dollars on to other market participants and driving up the prices of insurance policies." JA 170-71.

c. Plaintiffs are thus quite wrong to analyze the constitutionality of the minimum coverage provision through the lens of "inactivity," rather than by reference to "broad principles of economic practicality," *Lopez*, 514 U.S. at 571 (Kennedy, J.,

concurring). The Supreme Court has long held that "questions of the power of Congress are not to be decided by reference to any formula" without regard to "the actual effects of the activity in question upon interstate commerce." *Wickard*, 317 U.S. at 120; *see also Darby*, 312 U.S. at 118, 124 (referring to "practica[l] impossibility" of targeting only interstate shipments and employers and holding that Congress may "resort to all means for the exercise of a granted power which are appropriate and plainly adapted to the permitted end"); *Swift Co. v. United States*, 196 U.S. 375, 398 (1905) ("[C]ommerce among the States is not a technical legal conception, but a practical one, drawn from the course of business."); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962) (Congress in the Clayton Act "prescribed a pragmatic, factual approach to the definition of the relevant market").

Thus, federal statutes address practical economic circumstances, and may be triggered even when individuals have not engaged in affirmative "activity" in the narrow sense used by plaintiffs. For example, under the Superfund Act, a property owner may be subject to a remediation order whether or not he has engaged in interstate commerce and without any showing that he caused the contamination. 42 U.S.C. § 9607(a). Even a former property owner may be subject to a remediation order if he permitted hazardous waste to leak on his property "without any active human participation." *Nurad, Inc. v. William E. Hooper & Sons Co.*, 966 F.2d 837,

845 (4th Cir. 1992). The property owner's characterization of his own behavior as "passive" is irrelevant; otherwise, "an owner could insulate himself from liability by virtue of his passivity," defeating the remedial purposes of the Superfund Act. *Ibid.* Similarly, federal laws regulating child pornography are triggered even when an individual comes into possession of child pornography innocently, without having taken any active measures. Such an individual is required to take reasonable steps to destroy the visual depictions or report the matter to law enforcement officials. 18 U.S.C. § 2252(c). *See also* Second Militia Act of 1792, ch.38, § 1, 1 Stat. 264, 265 (requiring all free men to obtain firearms, ammunition, and other equipment); *Nortz v. United States*, 294 U.S. 317, 328 (1935) (sustaining requirement that persons holding gold bullion, coin, or certificates exchange them for paper currency).

4. The Affordable Care Act regulates interstate activity making national regulation particularly appropriate, and bears no resemblance to the statutes held invalid in *Lopez* and *Morrison*.

a. Plaintiffs' attempt to analogize the minimum coverage provision to the statutes at issue in *Lopez* and *Morrison* echoes the arguments that the Supreme Court rejected in *Raich*. "In their myopic focus" on *Lopez* and *Morrison*, plaintiffs "overlook the larger context of modern-era Commerce Clause jurisprudence preserved by those cases." *Raich*, 545 U.S. at 23.

The statutes at issue in *Lopez* and *Morrison* were stand-alone measures that

involved no economic regulation. In *Lopez*, the Supreme Court struck down a ban on possession of handguns in school zones because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might ultimately undermine economic productivity. Similarly, in *Morrison*, the Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to connect gender-motivated violence with interstate commerce. Neither of these measures played any role in broader regulation of economic activity, and the "noneconomic, criminal nature of the conduct at issue was central" to the decisions. *Morrison*, 529 U.S. at 610; *see also Sabri v. United States*, 541 U.S. 600, 607 (2004).

The minimum coverage provision, in contrast, concerns intrinsically economic activity by requiring health insurance as the means of payment for services in the interstate health market. It is not a stand-alone measure. It is part of a broad economic regulation of health care financing in the massive interstate health care market, and it is essential to the Act's regulation of underwriting practices in the insurance industry. It is difficult to conceive of legislation more clearly economic than the Act's regulation of the means of payment for health care services and the requirements placed on insurers, employers, and individuals made insurable by the Act. Far from the chain of attenuated reasoning required in *Lopez* and *Morrison* to identify any

substantial effect on interstate commerce, the link to interstate commerce in this case is direct and compelling.

b. Plaintiffs disregard the concern that animated *Lopez* and *Morrison*, which was to avoid a view of economic causation so broad that it would "obliterate the distinction between what is national and what is local in the activities of commerce." *Morrison*, 529 U.S. at 608 (quoting *Lopez*, 514 U.S. at 557). Plaintiffs do not and could not contend that the Affordable Care Act intrudes into an area of regulation that is reserved to the states, or that the problems besetting our health care system can be solved comprehensively on a state-driven basis. "Affordable health care is a national problem that demands a national solution." Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 New England J. Med. e29, at *3 (2010).

The modern health care system is interdependent and operates across state boundaries. 42 U.S.C.A. § 18091(a)(2)(B). Most health insurance is sold by national or regional companies that operate interstate, and it covers costs for medical supplies, drugs, and equipment shipped in interstate commerce. *Ibid.* Likewise, providers and insurers are joined in national networks, and consumers cross state lines to obtain health care services. "Hospitals are regularly engaged in interstate commerce, performing services for out-of-state patients and generating revenues from out-of-state sources." *Freilich*, 313 F.3d at 213.

These phenomena have been amplified by modern transportation, which, the Supreme Court acknowledged, has expanded the contours of Congress's commerce power. *See Heart of Atlanta Motel v. United States*, 379 U.S. 241, 251 (1964). Given the ease of travel, illnesses can spread rapidly and individuals can suddenly need health care services far from home.[4] In some cases, consumers travel to obtain services not readily available in their own state. For example, this Court noted in *Hoffman*, 126 F.3d at 587, "that many women travel across state lines to obtain reproductive health care, that facilities providing these services retain staff in an interstate employment market and utilize supplies obtained through interstate commerce." Similarly, residents of southwestern Pennsylvania make more than 1500 emergency room visits to a teaching hospital in West Virginia. *See* Amicus Br. of the Governors of Washington, Colorado, Michigan, and Pennsylvania, *State of Florida v. HHS*, No. 3:10-cv-91 (N.D. Fla.), at 9 (noting also that a medical center in Seattle is the only Level 1 trauma center for the four-state region of Washington, Alaska, Montana, and Idaho).

Prior to the Affordable Care Act, this mobility created potential disincentives

[4] Congress also understood that interstate mobility itself created the conditions for the spread of disease. *See* H.R. Rep. No. 111-299(I) at 744 (2009).

for individual states to adopt comprehensive reform of health insurance.[5] A state might reasonably have resisted providing more generous benefits or broader coverage than its neighboring states out of concern that it would become "a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose." *Helvering v. Davis*, 301 U.S. 619, 644 (1937). In addition, a state considering reforming discriminatory insurance practices might have worried that insurers – mostly regional or national companies, 42 U.S.C.A. § 18091(a)(2)(B) – would respond to such regulations "simply by pulling up stakes" (particularly if the state's reforms lacked a minimum coverage provision). Rosenbaum, *supra*, at e29; *see* p. 30*, supra* (explaining that insurers withdrew from Maine in the absence of a minimum coverage requirement). This circumstance contrasts sharply with the situations in *Lopez* and *Morrison*, which the Court found involved traditional subjects of state criminal law enforcement focused on local actors.

Moreover, regulation of health care and health care insurance implicates mobility between jobs and among states, considerations absent in *Lopez* and *Morrison*. Health insurance is very often an element of employees' compensation. If employees

[5] *See* 156 Cong. Rec. 1824, 1835 (daily ed. Mar. 21, 2010) (Rep. McGovern) ("We have already taken important steps in Massachusetts to deal with the health care issue. ... [And in light of the Affordable Care Act], we will no longer be forced to subsidize through higher premiums and higher Medicare and Medicaid costs the uncompensated care of people in other States who do not have health insurance.").

put their insurance at risk when they change jobs, they may be "reluctant to switch jobs in the first place (a phenomenon known as 'job lock')." CBO, Key Issues at 8. As Congress understood, the prospect of losing employee insurance benefits may obstruct interstate mobility, which the Constitution generally, and the commerce power specifically, were designed to prevent. *Heart of Atlanta*, 379 U.S. at 253 (noting the "uncertainty stemming from racial discrimination had the effect of discouraging travel").

Given these realities, it was more than rational for Congress to address the challenges of a state-driven approach to health care by enacting national reforms. *See Hodel v. Virginia Surface Min. & Reclamation Ass'n*, 452 U.S. 264 (1981) (Congress acted within its "traditional role ... under the Commerce Clause" in finding that national coal mining standards were necessary because states might limit conservation efforts in response to interstate competition among cost sellers); *Darby*, 312 U.S. at 122-23; *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937)

This Court has repeatedly held that Congress can regulate matters that relate to the cross-border challenges associated with health care and other markets. For example, because "[r]eports concerning [physician] peer review proceedings are routinely distributed across state lines and affect doctors' employment opportunities throughout the Nation," there is "no doubt concerning the power of Congress to

regulate a peer review process." *Freilich*, 313 F.3d at 213 (quotation marks omitted). Similarly, in upholding the Freedom of Access to Clinic Entrances Act, this Court reasoned that although the obstruction of clinic entrances "is not itself commercial or economic in nature, it is closely connected with, and has a direct and profound effect on, the interstate commercial market in reproductive health care services." *Hoffman*, 126 F.3d at 588.

Moreover, in *Gibbs v. Babbitt*, 214 F.3d 483 (4th Cir. 2000), this Court upheld a statute that barred the taking of a red wolf on private land, noting that "[f]armers and ranchers take wolves mainly because they are concerned that the animals pose a risk to commercially valuable livestock and crops," and that red wolves generated tourism and scientific research as well as trade. *Id.* at 492. The Court observed that, "[w]hile a beleaguered species may not presently have the economic impact of a large commercial enterprise, its eradication nonetheless would have a substantial effect on interstate commerce." *Id*. at 493. *See also Gould*, 568 F.3d at 475 ("A complex regulatory program ... 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.") (quoting *Hodel v. Indiana*, 452 U.S. 314, 329 n. 17 (1981)).

c. Plaintiffs invoke federalism concerns, but their quarrel, at bottom, is not with the assertion of federal commerce power, but with any government requirement that they maintain health insurance coverage. In plaintiffs' view, "if the district court's view of the Commerce Clause were true, then Congress could force those who dislike vegetables to purchase and consume them using the rationale that everyone has to eat, and vegetables are more healthful than fast food." Pl. Br. 24. This rhetoric has nothing to do with interstate commerce or the federalism limitations in the Constitution, which "deal with the exercise or reservation of powers, not rights." *District of Columbia v. Heller*, 554 U.S. 570, 579 (2008).

Insofar as the issue is "liberty," it would not matter whether a state or federal government undertook the regulation. Plaintiffs would object – to take their own example – if a state government tried to tell them what they could eat. Such a claim, however, would properly be analyzed under the Due Process Clause, *see Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261 (1990), but it is very different from plaintiffs' claim here. Plaintiffs' claim relates not to any right the Court has recognized as fundamental, but rather to a purported right to consume health care services without insurance and to pass overwhelming costs on to other market participants. Such challenges to economic regulation have had no legal support since the *Lochner* era.

Plaintiffs' analogy to a hypothetical requirement that every American "buy a General Motors vehicle," Pl. Br. 17, is also inapt and disregards every salient feature of the minimum coverage provision. Plaintiffs' hypothetical statute is simply a directive to support a corporation by buying its products. The minimum coverage provision, in contrast, requires non-exempted health care consumers to maintain insurance coverage so that they will not add to the staggering burden of uncompensated health care costs. For plaintiffs' automotive analogy even to begin to make sense, it must assume a fictional world in which every individual (1) is necessarily in the car market because he may develop a sudden, unforeseen need to have an expensive car, and (2) is entitled to receive the car regardless of his ability to pay. Crucially, plaintiffs' analogy would still fail, as a parallel statute would not require the purchase of a car but rather the purchase of a financial product to finance a car when the need for one arises.

Although plaintiffs insist that the minimum coverage provision represents a "threat[]" to the "liberty of all Americans," it is undisputed that Congress could have compelled workers to obtain health insurance from a single payer and to pay for that coverage through a mandatory tax. *Cf. Helvering*, 301 U.S. at 640-45. Congress instead established a minimum coverage requirement that provides consumers with enhanced flexibility in purchasing policies in the private market, subject to a tax

penalty for noncompliance. Nothing in the Constitution prohibits Congress from employing these means, and with respect to plaintiffs' articulated concerns, the tax penalty mechanism is, indeed, a more modest step.

Plaintiffs' rhetoric is particularly anomalous in light of Affordable Care Act provisions that confer significant benefits on people, like plaintiffs, who are not currently insured. As discussed, the Act guarantees that people like plaintiffs are insurable and protects them from the risk of being left destitute by catastrophic medical expenses. *See* 42 U.S.C.A. § 18091(a)(2)(G) (62% of all personal bankruptcies are caused in part by medical expenses). Even apart from the other rational bases for Congress's choice of means, "[t]his benefit makes imposing the minimum coverage provision appropriate." *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010), *appeal pending*, No. 10-2388 (6th Cir.).

At the end of the day, evaluation of whether an action by Congress is necessary and proper calls for a deferential examination of the legislation in question, its factual context, and Congress's reasons for acting. The analysis cannot be driven by hypothetical statutes that no legislature would ever adopt. Congress's commerce power to enact minimum wage legislation, *Darby*, 312 U.S. 100, is not defeated because, hypothetically, Congress could use that power to set a minimum wage of $5,000 per hour. As Chief Justice Marshall explained long ago, "[t]he 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, as that, for example, of declaring war, the sole restraints on which they have relied, to secure them from its abuse. They are the restraints on which the people must often rely solely, in all representative governments." *Gibbons v. Ogden*, 22 U.S. 1, 197 (1824) (Marshall, C.J.). Justice Story likewise recognized that it is manifestly incorrect to suggest that "because Congress had not hitherto used a particular means to execute any ... given power, therefore it could not now do it." 3 Joseph Story, *Commentaries on the Constitution of the United States* § 1132, at 39 (1833). Such a rule would mean that "if [C]ongress had never provided a ship for the navy, except by purchase, [it] could not now authorize ships to be built for a navy"; that "[i]f [Congress] had not laid a tax on certain goods, it could not now be done"; or that "[i]f [Congress] had never erected a custom-house, or a court-house, [Congress] could not now do it." *Ibid.* That "mode of reasoning would be deemed by all persons wholly indefensible." *Ibid.*

The minimum coverage provision is, in short, very plainly adapted to regulate payments in the unique circumstances of the health care services market.

C. The employer responsibility provision is a valid exercise of the commerce power.

The employer responsibility provision complements the minimum coverage provision by imposing a tax penalty on large employers that fail to offer their full-time employees adequate coverage, if at least one of their full-time employees receives a tax credit to assist with the purchase of coverage through a health insurance exchange.

Regulating employer provision of health care is hardly novel. Congress has for decades regulated the content and availability of group health insurance plans offered by large employers under ERISA, 29 U.S.C. §§ 1001 *et seq*., and other statutes. In enacting the employer responsibility provision, Congress found that "employers who do not offer health insurance to their workers gain an unfair economic advantage relative to those employers who do provide coverage, and millions of hard-working Americans and their families are left without health insurance." H.R. Rep. No. 111-443(II), at 985 (2010). Congress noted that this state of affairs results in "a vicious cycle because these uninsured workers turn to emergency rooms for health care which in turn increases costs for employers and families with health insurance," making it more difficult for employers to provide coverage. *Id.* at 985-86.

It has been settled at least since *Darby* and *NLRB v. Jones & Laughlin Steel Corp.,* 301 U.S. 1 (1937), that the commerce power authorizes the regulation of wages, hours, and other terms of employment. JA 173. In attempting to distinguish this

longstanding precedent, plaintiffs assert that the employer responsibility provision "mandates that private employers enter into agreements with other private businesses to provide health insurance dictated by the government." Pl. Br. 25. In reality, many large employers self-insure. CBO, Key Issues, at 6. In any event, there is no support for the proposition that a regulation of interstate commerce is suspect if compliance requires a contract with a third party.

II. The Minimum Coverage and Employer Responsibility Provisions Are Also Independently Authorized by Congress's Taxing Power.

The district court correctly upheld the minimum coverage and employer responsibility provisions as valid exercises of Congress's commerce power, and thus did not need to decide whether these provisions are also valid exercises of Congress's power to "lay and collect taxes." U.S. Const., art. I,§ 8, cl. 1. If this Court were to consider the issue, the provisions are also valid exercises of the taxing power, which is "comprehensive," *Steward Mach. Co.*, 301 U.S. at 581-82, and "plenary," *Murphy v. IRS*, 493 F.3d 170, 182-83 (D.C. Cir. 2007).

A tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States v. Sanchez*, 340 U.S. 42, 44 (1950). As long as a statute is "productive of some revenue," Congress may exercise its taxing powers irrespective of any "collateral inquiry as to the measure of the regulatory effect of a tax." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see*

also Bob Jones Univ. v. Simon, 416 U.S. 725, 741 n.12 (1974) (noting that the Court has "abandoned" older "distinctions between regulatory and revenue-raising taxes"). In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson*, 312 U.S. at 363; *see also United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by operation of Internal Revenue Code had "essential character as taxes" despite statutory label as "penalties").

The minimum coverage provision amends the Internal Revenue Code to provide that a non-exempt individual who fails to maintain a minimum level of insurance shall pay a monthly tax penalty for so long as he fails to do so. 26 U.S.C.A. § 5000A. The practical operation of the provision is as a tax. Individuals who are not required to file income tax returns for a given year are not required to pay the penalty. *Id.* § 5000A(e)(2). The amount of any penalty is calculated in part by reference to household income for federal tax purposes; it is reported on the individual's federal income tax return for the taxable year and is assessed and collected in the same manner as certain other federal tax penalties. *Id.* § 5000A(b)(2), (c)(1), (2), (g). The taxpayer's responsibility for family members depends on their status as dependents under the Internal Revenue Code. *Id.* § 5000A(a), (b)(3). And the Secretary of the Treasury is empowered to enforce the penalty provision. *Id.* § 5000A(g). By creating

a liability that must be reported on the taxpayer's federal income tax return and granting enforcement authority to the Secretary of the Treasury, the provision operates as a taxing measure. *See In re Leckie Smokeless Coal Co*., 99 F.3d 573, 583 (4th Cir. 1996).

The employer responsibility provision amends the Internal Revenue Code to impose a penalty on any applicable large employer that fails to offer its full-time employees adequate coverage for any month, if at least one of the employer's full-time employees receives a tax credit to assist with the purchase of coverage through a health insurance exchange in that month. 26 U.S.C.A. § 4980H(a). Like the penalty component of the minimum coverage provision, the practical operation of this provision is as a tax and, under the statute, it shall be assessed and collected in the same manner as other assessable penalties imposed under the Internal Revenue Code. *Id.* § 4980H(d).

There is no dispute that these provisions will be "productive of some revenue." *Sonzinsky*, 300 U.S. at 514. The CBO estimated that the minimum coverage provision will yield $4 billion each year, and the employer responsibility provision will produce $11 billion by 2019. Letter from Elmendorf to Pelosi, Speaker, U.S. House of Representatives, *supra*, table 4; *see also* Pub. L. No. 111-148, § 1563(a)(1), 124 Stat. 119, 270 (finding that the Act "will reduce the Federal deficit").

Contrary to plaintiffs' assertions, Congress was not required to invoke its taxing power explicitly or to label the payments "taxes." *See Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948) ("constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise"); *Leckie*, 99 F.3d at 576, 586 ("premium" on coal operators is an exercise of taxing power despite Commerce Clause findings). The Constitution itself uses four different terms to refer to the concept of taxation: tax, impost, duties, and excises. U.S. Const., art I, § 8, cl. 1. Congress likewise used the terms "tax" and "assessable payment" interchangeably in the employer responsibility provision. 26 U.S.C.A. § 4980H(b)(1), (2). In drafting the Act, Congress repeatedly referred to the penalties as taxes, and during legislative debates congressional leaders explicitly defended the provisions as an exercise of the taxing power. *See* 156 Cong. Rec. H1854, H1882 (Mar. 21, 2010) (Rep. Miller); *id.* at H1824, H1826 (Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (Dec. 22, 2009) (Sen. Leahy); *id.* at S13,558, S13,581-82 (Dec. 20, 2009) (Sen. Baucus); *see also* H.R. Rep. No. 111-443(I), at 265 (2010).

The taxing power may not be used to impose "punishment for an unlawful act." *United States v. LaFranca*, 282 U.S. 568, 572 (1931). But the minimum coverage and employer responsibility provisions do not impose "punishment." Neither applies retrospectively; instead they impose month-to-month penalties for failures to obtain

or provide adequate coverage, with liability ceasing when adequate coverage is obtained or provided. 26 U.S.C.A. § 5000A(a)-(c); *id.* § 4980H(a), (b). Penalty amounts are subject to specified limits. *E.g.*, 26 U.S.C.A. § 4980H(b)(2). Under the minimum coverage provision, the tax cannot exceed the cost of qualifying insurance, *id.* § 5000A(c). (Indeed, the minimum coverage provision even has a "hardship" exemption, *id.* § 5000A(e)(5), and bars criminal prosecution for failure to obtain coverage, *id.* § 5000A(g)(2)(A).)

In short, the minimum coverage and employer responsibility provisions are taxes in both administration and effect. They are enforced through the Internal Revenue Service and — in conjunction with the rest of the Act — have been determined by the CBO and Congress to reduce the budget deficit. And any doubt as to the meaning of the words in the Affordable Care Act should be construed in favor of the statute's constitutionality. *Northwest Austin Mun. Utility Dist. No. One v. Holder*, 129 S. Ct. 2504, 2513 (2009); *Ashwander v. TVA*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring).

Plaintiffs do not raise their tax apportionment claim on appeal, and the argument is thus waived. In any event, the district court correctly held that the Constitution's apportionment requirement does not apply to assessments that are enacted in aid of valid Commerce Clause legislation. JA 195. Moreover, even if the provisions were

analyzed solely as exercises of the taxing power, they do not impose "capitation" taxes subject to the apportionment requirement. A capitation tax is one imposed "simply, without regard to property, profession, or any other circumstance." *Hylton v. United States*, 3 U.S. 171, 175 (1796) (opinion of Chase, J.); *Pac. Ins. Co. v. Soule*, 74 U.S. 433, 444-46 (1868) (adopting Justice Chase's definition); *Veazie Bank v. Fenno*, 75 U.S. 533, 544 (1869). The minimum coverage and employer responsibility provisions do not impose flat taxes without regard to the taxpayer's circumstances. The employer tax depends on whether a large employer offers adequate coverage to its full-time employees. 26 U.S.C.A. § 4980H. The penalty for a failure to maintain minimum coverage is assessed on a monthly interval, based on how the taxpayer elects to pay for health care services. *Id*. § 5000A(a), (b)(1). These provisions thus resemble other federal taxes imposed for failures to make specified economic arrangements.[6]

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

III. The District Court Correctly Rejected Plaintiffs' Religion-Based Objections to the Minimum Coverage Provision.

Plaintiffs' religion-based objections to the minimum coverage provision are insubstantial for the reasons discussed by the district court. *See* JA 177-90. Plaintiffs assert that the minimum coverage provision violates their free exercise rights by requiring that they pay for procedures that "are antithetical to their religious beliefs." Pl. Br. 48; *see also* Complaint ¶151. The only such procedures identified in the complaint are abortion procedures, and plaintiffs "fail to allege how any payments required under the Act, whether fines, fees, taxes, or the cost of the policy, would be used to fund abortion," JA 186; *see also* JA 187 (dismissing RFRA claim because plaintiffs' "conclusory allegations" do not establish a substantial burden on their free exercise). To the extent plaintiffs argue that the Act is inconsistent with other facets of their religious beliefs, the argument was waived. JA 184 n.17.

In any event, "[t]he Free Exercise Clause does not excuse individuals from compliance with neutral laws of general applicability." JA 184. The minimum coverage provision is a law of general applicability because it does not "impose burdens only on conduct motivated by religious belief." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 543 (1993).

Plaintiffs' challenges to the exceptions to the minimum coverage provision are equally unavailing. The Supreme Court has "'long recognized that the government

may ... accommodate religious practices ... without violating the Establishment Clause.'" JA 178 (quoting *Cutter v. Wilkinson*, 544 U.S. 709, 713 (2005)). The "health care sharing ministry" provision exempts members of § 501(c)(3) organizations that have been in existence since 1999, that share a common set of ethical or religious beliefs, that share medical expenses among their members in accordance with those beliefs, and whose members retain membership even after they develop a medical condition. 26 U.S.C.A, § 5000A(d)(2)(B). The "religious conscience exemption" incorporates a longstanding provision of the Internal Revenue Code that applies to individuals who adhere to established tenets or teachings of religious sects in existence since 1950 that are "conscientiously opposed to acceptance of the benefits of any private or public insurance" (including Medicare, Medicaid, and Social Security benefits). *Id.* § 5000A(d)(2)(A) (incorporating the definition of "religious sect" in 26 U.S.C. § 1402(g)(1)). Section 1402(g)(1) of the Internal Revenue Code was enacted as part of the Social Security Amendments of 1965 "primarily because religious sects like the Old Order Amish provided for their own needy, independent of public or private insurance programs." *Varga v. United States*, 467 F. Supp. 1113, 1117 (D. Md. 1979) (citing S. Rep. No. 89-404, at 116 (1965)), *aff'd*, 618 F.2d 106 (4th Cir. 1980).

These provisions are neutral because they define eligibility based on

characteristics that cut across denominations. *Cutter*, 544 U.S. at 720. The courts of appeals have uniformly upheld the § 1402(g) exemption because it "does not discriminate among religions" but rather "accommodates, consistent with the goals of the Social Security system, those who oppose Social Security on religious grounds." *Droz v. Comm'r, IRS*, 48 F.3d 1120, 1124 (9th Cir. 1995) (citing cases).

These exemptions easily withstand rational basis review. As discussed, the minimum coverage provision regulates the means of payment for services obtained in the national health care market. It was eminently rational for Congress to exempt individuals who belong to groups with established records of providing for the medical needs of their members without participating in the general health care market. JA 190. Clearly, Congress was not also required to exempt individuals, like plaintiffs, who instead participate in the interstate health care market.

CONCLUSION

The judgment of the district court should be affirmed.

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CERTIFICATE OF COMPLIANCE

I hereby certify that, according to the word count provided in Corel WordPerfect 12, the foregoing brief contains 13,946 words. The text of the brief is composed in monospaced, 12-point Courier New typeface, which has 10 characters per inch.

The text of the hard copy of this brief and the text of the "PDF" version of the brief filed electronically through ECF ("the E-brief") are identical. A virus check was performed on the E-brief, using Microsoft Forefront Client Security software (version 1.5.1973.0), and no virus was detected.

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CERTIFICATE OF SERVICE

I hereby certify that on February 18, 2011, I filed and served the foregoing Brief for the Federal Appellees with the Clerk of the Court by causing a copy to be electronically filed via the appellate CM/ECF system. I also hereby certify that I have caused copies to be delivered to the Court by Federal Express, and caused copies to be served upon the following counsel by electronic mail and Federal Express:

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