UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO

U.S. CITIZENS ASSOCIATION, *et al.*,	)	
	)	
Plaintiffs,	)	Case No: 5:10-cv-1065
	)	
v.	)	Judge David Dowd, Jr.
	)	
BARACK H. OBAMA, *et al.*,	)	
	)	
Defendants.	)	
	)	

MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' SECOND AMENDED COMPLAINT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Cases (cont.):

Cases (cont.):

Cases (cont.):

Cases (cont.):

Cases (cont.):

Cases (cont.):

Cases (cont.):

Constitution and Statutes:

Constitution and Statutes (cont.):

Constitution and Statutes (cont.):

Legislative Materials:

Miscellaneous:

Miscellaneous (cont.):

STATEMENT OF ISSUES

1. Whether plaintiffs have standing to challenge the minimum coverage provision of the Patient Protection and Affordable Care Act ("ACA"), which does not take effect until January 1, 2014, and may not affect, let alone injure, plaintiffs even then.

2. Whether plaintiffs' challenge to the minimum coverage provision is ripe, given that the provision does not take effect until January 1, 2014, and may not affect, let alone injure, plaintiffs even then.

3. Whether the Anti-Injunction Act, 26 U.S.C. § 7421(a), bars plaintiffs from obtaining an injunction against the assessment or collection of the penalty that they might be required to pay under the minimum coverage provision.

4. Whether, if this Court determines that it has subject matter jurisdiction, plaintiffs have stated a claim that they are entitled to relief.

A. Whether the ACA is a proper exercise of Congress's power to regulate interstate commerce or its authority to collect revenue and make expenditures for the general welfare.

B. Whether the ACA is consistent with the First Amendment protections of free association, given that the Act places no burden on plaintiffs' ability to combine with others to advance their views about health insurance, and the Act neither burdens plaintiffs' relationship with their medical practitioners, nor forces them to enter into unwanted relationships with medical practitioners.

C. Whether the ACA is consistent with the Fifth Amendment's due process protection, when the right not to purchase health insurance is not a fundamental liberty interest and the Act does not require that plaintiffs release private information to health insurers.

SUMMARY OF ARGUMENT

Plaintiffs challenge the minimum coverage provision established by Section 1501 of the Patient Protection and Affordable Care Act ("ACA"). The Court lacks subject matter jurisdiction to hear plaintiffs' claims. Even if the Court had jurisdiction, plaintiffs have failed to state a claim that they are entitled to relief.

The Court lacks subject matter jurisdiction because plaintiffs do not have standing to challenge the minimum coverage provision. That provision does not take effect until 2014, and may not affect, let alone injure, plaintiffs even then. Because plaintiffs' claims turn on speculation as to the possibility of a future injury, under *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 564 n.2 (1992), and *Rosen v. Tennessee Commissioner of Finance & Administration*, 288 F.3d 918, 929 (6th Cir. 2002), they lack an injury-in-fact, which is a prerequisite for Article III standing. Furthermore, plaintiffs cannot manufacture an injury-in-fact by asserting that they are preparing now for the possibility that the minimum coverage provision may apply to them in the future, as any such "harm" reflects their own voluntary choices regarding how to arrange their financial affairs, and is not fairly traceable to the ACA. *See Sanner v. Bd. of Trade of City of Chi.*, 62 F.3d 918, 923-24 (7th Cir. 1995).

For similar reasons, plaintiffs' challenge to the minimum coverage provision is not ripe for adjudication. A claim is not ripe if it turns on contingent future events that may not occur as anticipated. *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985). As stated above, it is speculative whether plaintiffs will be subject to the minimum coverage provision once it becomes effective.

Further, plaintiffs' challenge to the minimum coverage provision is barred under the Anti-Injunction Act, 26 U.S.C. § 7421(a). A non-exempt person who is subject to the

minimum coverage provision and who fails to obtain qualifying insurance coverage may incur a penalty added to his or her income tax. The Anti-Injunction Act requires that any challenge to the assessment or collection of the penalty be brought in a suit for a refund, not in a pre-enforcement suit such as this one. *Bob Jones Univ. v. Simon*, 416 U.S. 725, 736 (1974).

Furthermore, even if this Court had jurisdiction, plaintiffs fail to state a claim for relief. First, Congress acted within its Article I powers in adopting the ACA and the minimum coverage provision. The statute regulates the interstate health insurance market—in particular, by barring insurers from denying coverage or charging discriminatory rates to individuals who have pre-existing medical conditions. That regulation is indisputably within Congress's commerce power. Congress reasonably determined that the minimum coverage provision was essential for these larger reforms to work, and the provision is necessary and proper to this exercise of the commerce power. *Gonzales v. Raich*, 545 U.S. 1, 22 (2005). In addition, the minimum coverage provision regulates economic conduct with substantial effects on interstate commerce, namely, individual decisions regarding how to pay for health care—in advance, through insurance, or later, out-of-pocket. The decisions of some individuals to forgo insurance, in the aggregate, shift $43 billion of costs onto other participants in the health care market. Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a) (2008 figures); *see also Raich*, 545 U.S. at 22; *United States v. Faasse*, 765 F.3d 475, 486 (6th Cir. 2001) (en banc). Moreover, the minimum coverage provision—which is codified in the Internal Revenue Code and which includes a tax penalty reflected on individuals' tax returns and paid with their annual income tax—is also a valid exercise of Congress's power to collect revenue and make expenditures for the general welfare.

Plaintiffs also claim that the minimum coverage provision violates the Constitution's protection of the freedom of association. First, the ACA does not impinge on the First Amendment's protection of expressive association because, even if it could somehow be construed as a requirement to "associate" with insurers, it imposes no burden on plaintiffs' ability to express, or to refrain from expressing, any message, within the protections of the First Amendment. *See Rumsfeld v. Forum for Academic & Institutional Rights, Inc.* (*"FAIR"*), 547 U.S. 47, 69-70 (2006). Additionally, the provision does not violate the Constitution's protection of intimate association because, even if the relationship between a patient and a medical practitioner qualifies as an "intimate human relationship," *Roberts v. U.S. Jaycees*, 468 U.S. 609, 617 (1984), the ACA neither burdens plaintiffs' relationships with practitioners nor forces them to seek unwanted medical care.

Plaintiffs further assert that the minimum coverage provision violates due process by requiring them to obtain health insurance, or by requiring them to disclose personal medical information. But if there exists some previously unrecognized right not to purchase health insurance, it is by no means a fundamental liberty interest. *See Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997). Nor does the provision implicate any due process right to keep personal information private. The Act requires no such disclosure, and plaintiffs' speculation as to the information that private insurers will request in the future does not come within the exceedingly narrow circumstances in which courts have recognized such a right. *See Summe v. Kenton Co. Clerk's Office*, 604 F.3d 257, 270 (6th Cir. 2010).

INTRODUCTION

Plaintiffs—an association devoted to promoting particular values, and two of its members—launch a scattershot attack on recently enacted federal health care reform legislation. Their numerous claims amply establish their distaste for the new statute. But that alone does not establish a case or controversy, much less justify overturning the policy judgments of the democratically accountable branches of the United States government.

Plaintiffs' claims fail on jurisdictional grounds before the Court can even reach the merits. First, plaintiffs do not satisfy the threshold requirement for standing: an injury-in-fact. The minimum coverage provision at the center of each of plaintiffs' claims—Section 1501 of the Patient Protection and Affordable Care Act ("ACA"), which, subject to certain exceptions, requires individuals either to obtain a minimum level of health insurance or to pay a penalty—does not take effect until 2014. Plaintiffs speculate that this minimum coverage provision will harm them once it is in force, and allege that they must now take steps to prepare for the ACA's potential application. Neither assertion states an injury-in-fact sufficient to satisfy Article III. For similar reasons, plaintiffs' claims are not ripe for review. In addition, plaintiffs seek what the Anti-Injunction act specifically forbids—an injunction against the tax assessments they might face under the minimum coverage provision in 2014 and later years.

Even if plaintiffs could surmount these and other jurisdictional barriers, their claims still would fail, because Congress, in adopting the minimum coverage provision, acted well within its authority under the Commerce Clause and the Necessary and Proper Clause. The ACA put in place comprehensive reforms of the interstate health insurance market, including a ban on denying coverage to, or charging more for, any individual based on a preexisting

medical condition. And Congress determined that, without the minimum coverage provision, those market reforms would not work, as they would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," shifting even greater costs onto third parties. Pub. L. No. 111-148, §§ 1501(a)(2)(I), 10106(a). Congress thus found that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* As has been recognized by the only court to date that has ruled on the merits on this issue, Congress has the power under the Commerce Clause and the Necessary and Proper Clause to enact provisions to ensure the viability of its larger regulations of interstate commerce. *Thomas More Law Ctr. v. Obama*, No. 2:10-cv-11156, slip op. at 18 (E.D. Mich. Oct. 7, 2010) (Exhibit A).

Congress further understood, and plaintiffs do not deny, that virtually everyone at some point needs medical services, which cost money. The ACA regulates economic decisions about how to pay for those services—whether to pay in advance through insurance or to attempt to do so later out-of-pocket—decisions that, "in the aggregate," substantially affect the vast, interstate health care market. *See Gonzales v. Raich*, 545 U.S. 1, 22 (2005). More than 50 million Americans have neither private health insurance nor the protection of government programs such as Medicare or Medicaid. U.S. CENSUS BUREAU, INCOME, POVERTY, & HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22 (Sept. 2010) [hereinafter CENSUS BUREAU, INSURANCE COVERAGE]. Many of these individuals are uninsured because they cannot afford coverage. Others are excluded by insurers' restrictive underwriting criteria. Still others make the economic decision to forgo health insurance altogether with the backdrop of "free" healthcare in the event of a critical illness or accident.

Forgoing health insurance, however, is not the same as forgoing health care. When accidents or illnesses inevitably occur, the uninsured still receive essential medical care, even if they cannot pay. As Congress documented, the cost of such uncompensated health care, $43 billion in 2008 alone, is passed on to the other participants in the health care market: health care providers, insurers, the insured population, governments, and taxpayers. Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a). Congress's commerce power plainly enables it to address these substantial effects on the interstate market. *Thomas More*, slip op. at 16-17.

In addition, Congress has independent authority to enact the ACA as an exercise of its power under the General Welfare Clause of Article I, Section 8. *See License Tax Cases*, 72 U.S. (5 Wall.) 462, 471 (1867). Congress treated the minimum coverage provision as an exercise of the taxing power, lodging it in the Internal Revenue Code, specifying that the penalty under the provision be assessed and collected like any other tax, and invoking the taxing power throughout the legislative debates. The provision, moreover, bears the principal hallmark of a tax. It will raise revenue, and is therefore valid under longstanding precedent, even though Congress also had a regulatory purpose in enacting it.

Plaintiffs' remaining claims range even farther afield. The ACA in no sense infringes on the Constitution's protection of either expressive association or intimate association. The minimum coverage provision does not require plaintiffs to endorse the expressive message of any other individual or group, or to refrain from expressing their own views; indeed, it does not implicate the First Amendment at all. Furthermore, by no stretch of logic or precedent does the provision impinge on the supposed right of intimate association between plaintiffs and their medical practitioners. The ACA does not prevent plaintiffs from continuing to see a practitioner of their choice, and it does not require them to seek unwanted medical care.

Nor does the ACA violate the due process clause. Plaintiffs' asserted substantive due process right not to pay for insurance is a purely economic interest that, under law that has been settled since the New Deal, cannot give rise to a due process claim that requires anything more than the lowest level of scrutiny. Plaintiffs' informational privacy claim fares no better. Plaintiffs claim that the minimum coverage provision will require health insurance enrollees to disclose medical information in supposed violation of a right to informational privacy. This assertion, which speculates as to the future behavior of private entities, could not state a due process claim even if its allegations were more concrete; the Sixth Circuit has recognized a due process right to the privacy of personal information only in narrow circumstances that are not implicated here.

Reasonable people may disagree on how best to resolve the overriding problems in the interstate health care market, problems that threaten lives and livelihoods, jeopardize the competitive standing of American industry, and burden the federal budget. But those disagreements can move from the elected branches to the judicial arena only when a concrete case or controversy frames a genuine constitutional issue, and if it does, the legislative judgments warrant great deference. Plaintiffs' challenge to the minimum coverage provision does not present a case or controversy, and reflects not the slightest deference to the democratic process. It should be dismissed.

BACKGROUND

A. Statutory Background

In 2009, the United States spent more than an estimated 17% of its gross domestic product on health care. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a). Notwithstanding

these extraordinary expenditures, 50 million people—an estimated 16.7% of the population—went without health insurance for some portion of 2009. CENSUS BUREAU, INSURANCE COVERAGE 4, 9. Absent the new legislation, that number was projected to exceed 54 million by 2019. CONG. BUDGET OFFICE ("CBO"), 2008 KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 11 (Dec. 2008) [hereinafter KEY ISSUES]; *see also* CBO, THE LONG-TERM BUDGET OUTLOOK 21-22 (June 2009).

The record before Congress documents the staggering costs that a broken health care system visits on individual Americans and the Nation as a whole. The millions without health insurance coverage still receive medical care, but often cannot pay for it. The costs of that uncompensated care are shifted to health care providers, insurers, the insured, governments, and taxpayers. But cost shifting is not the only harm imposed by the lack of insurance. Congress found that the "economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured," Pub. L. No. 111-148, §§ 1501(a)(2)(E), 10106(a), and concluded that 62% of all personal bankruptcies are caused in part by medical expenses, *id.* §§ 1501(a)(2)(G), 10106(a). All these costs, Congress determined, have a substantial effect on interstate commerce. *Id.* §§ 1501(a)(2)(F), 10106(a).

In order to remedy this overriding problem for the American economy, the ACA comprehensively "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." *Id.* §§ 1501(a)(2)(A), 10106(a). First, to address inflated fees and premiums in the individual and small-business insurance market, Congress established health insurance Exchanges "as an organized and transparent marketplace for the purchase of health insurance where individuals and employees (phased-in over time) can shop and compare

health insurance options." H.R. REP. NO. 111-443, pt. II, at 976 (2010) (internal quotation omitted). The Exchanges coordinate participation and enrollment in health plans, and provide consumers with needed information regarding plans in the Exchanges. Pub. L. No. 111-148, § 1311.

Second, the ACA builds on the existing system of employer-sponsored health insurance, in which many individuals receive coverage as part of their employee compensation. *See* CBO, KEY ISSUES, at 4-5. It creates a system of tax incentives for small businesses to encourage the purchase of health insurance for their employees, and imposes assessments on certain large businesses that do not provide adequate coverage to their employees. Pub. L. No. 111-148, §§ 1421, 1513.

Third, the ACA subsidizes insurance coverage for a large portion of the uninsured population. As Congress understood, nearly two-thirds of the uninsured are in families with income less than 200% of the federal poverty level, H.R. REP. NO. 111-443, pt. II, at 978 (2010); *see also* CBO, KEY ISSUES, at 27, while only 4% of those with income greater than 400% of the poverty level are uninsured. CBO, KEY ISSUES, at 11. The ACA reduces this gap by providing health insurance premium tax credits and reduced cost-sharing for individuals and families with income between 133% and 400% of the federal poverty level, Pub. L. No. 111-148, §§ 1401-02, and by expanding eligibility for Medicaid to individuals with income below 133% of the federal poverty level beginning in 2014. *Id*. § 2001.

Fourth, the ACA removes barriers to insurance coverage. As noted, it prohibits widespread insurance industry practices that increase premiums for—or deny coverage entirely to—those with the greatest need for health care. Most significantly, the ACA bars insurers from refusing to cover or charging more for individuals with pre-existing medical

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

Finally, the ACA requires that all Americans, with specified exceptions, maintain a minimum level of health insurance coverage, or pay a penalty. *Id.* §§ 1501, 10106.[1] Congress found that this minimum coverage provision "is an essential part of this larger regulation of economic activity," and that its absence "would undercut Federal regulation of the health insurance market." *Id.* §§1501(a)(2)(H), 10106(a). That judgment rested on a number of Congressional findings. Congress found that, by "significantly reducing the number of the uninsured, the requirement, together with the other provisions of [the ACA], will lower health insurance premiums." *Id.* §§ 1501(a)(2)(F), 10106(a). Conversely, and importantly, Congress also found that, without the minimum coverage provision, the reforms in the ACA, such as the ban on denying coverage based on pre-existing conditions, would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," thereby further shifting costs onto third parties. *Id.* §§ 1501(a)(2)(I), 10106(a). Congress thus determined that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

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

The CBO projects that the reforms in the ACA will reduce the number of uninsured Americans by approximately 32 million by 2019. Letter from Douglas W. Elmendorf, Director, CBO, to the Rep. Nancy Pelosi, Speaker, U.S. House of Representatives 9 (Mar. 20, 2010) [hereinafter CBO Letter to Rep. Pelosi]. It further projects that the Act's combination of reforms and tax credits will reduce the average premium paid by individuals and families in the individual and small-group markets. *Id.* at 15; CBO, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION & AFFORDABLE CARE ACT 23-25 (Nov. 30, 2009). And CBO estimates that the interrelated revenue and spending provisions in the ACA—specifically taking into account revenue from the minimum coverage provision—will yield net savings to the federal government of more than $100 billion over the next decade. CBO Letter to Rep. Pelosi, at 2.

B. This Action

The U.S. Citizens Association ("USCA"), along with two[2] of its members, brought this action for injunctive and declaratory relief. Second Amended Complaint ("SAC") ¶¶ 12-15. The Complaint names as defendants the Secretary of the Department of Health and Human Services; the Secretary of the Treasury; the Attorney General; and the United States. SAC ¶¶ 16-19. The Complaint contains four counts, each challenging the ACA's minimum coverage provision as unconstitutional. Count One contends that the minimum coverage provision exceeds Congress's Article I powers. SAC ¶¶ 34-40. The remaining counts assert that the minimum coverage provision violates the guarantee of freedom of association under the First and Fifth Amendments, the due process clause of the Fifth Amendment, and

[2] Plaintiffs have moved to dismiss a third plaintiff, Eileen Dannemann. Docket #46. Defendants do not oppose this motion. If she were not dismissed, defendants' arguments would apply to her claims as well.

the constitutional right to privacy. SAC ¶¶ 41-56. As set forth below, each of these claims should be dismissed.

STANDARD OF REVIEW

Defendants move to dismiss the complaint for lack of subject matter jurisdiction under Rule 12(b)(1) of the Federal Rules of Civil Procedure. The party seeking to invoke federal jurisdiction "bears the burden [to] demonstrat[e] standing and must plead its components with specificity." *Coyne v. Am. Tobacco Co.*, 183 F.3d 488, 494 (6th Cir. 1999) (citation and internal quotation omitted). This Court must determine whether it has subject matter jurisdiction before addressing the merits of the complaint. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94-95 (1998).

Defendants also move to dismiss every count in the complaint under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted. Under this Rule, "the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions. Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009); *see also Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). [3]

[3] On August 2, Judge Henry E. Hudson, in the Eastern District of Virginia, issued a procedural decision denying the United States' motion to dismiss in *Virginia v. Sebelius*, 702 F.Supp.2d 598 (E.D. Va. 2010). The court did not rule on the merits of the Commonwealth's claim. Rather, Judge Hudson deferred a decision on the merits, finding an "arguable legal basis" for the Commonwealth of Virginia's claim on which the court desired further briefing. *Id.* at 612. For the reasons stated elsewhere in this brief, plaintiffs' claims fail under well-settled law. *See, e.g.*, *Baldwin v. Sebelius*, No. 10-1033, 2010 WL 3418436 (S.D. Cal. Aug. 27, 2010) (dismissing a similar challenge to the ACA because plaintiffs lacked standing). But even if this Court considered the legal questions to be closer, it should not deny a motion to dismiss on the reasoning of the Eastern District of Virginia that there is a *dispute of law*.

ARGUMENT

I. THIS COURT LACKS SUBJECT MATTER JURISDICTION

A. Plaintiffs Lack Standing

Federal courts sit to decide cases and controversies, not to resolve disagreements on policy or politics. To invoke the jurisdiction of this Court, plaintiffs must have standing to sue. And to have standing, they must show a present injury-in-fact. No plaintiff can even arguably suffer injury from the minimum coverage provision until 2014 at the earliest, and it is speculative whether any will suffer injury even then. Because neither the likelihood nor the extent of such an injury can be known now, plaintiffs cannot plead with specificity that they will be injured by the minimum coverage provision, as required by *Wuliger*, 567 F.3d at 793 (citation and internal quotation omitted).

1. Plaintiffs Cannot Show an Injury-in-Fact

To establish standing, "the plaintiff must have suffered an injury-in-fact—an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (citation, internal quotation, and footnote omitted). To meet this requirement, the harm must be "palpable and distinct." *Prime Media, Inc. v. City of Brentwood*, 485 F.3d 343, 352 (6th Cir. 2007) (citation and internal quotation omitted). "Allegations of possible future injury do not satisfy the requirements of Art. III. A threatened injury must be certainly impending to constitute injury in fact." *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990)

This Court must decide questions of law on a Rule 12(b)(6) motion, and if a plaintiff fails to state a claim under the governing law, the Court must dismiss the complaint, "without regard to whether it is based on an outlandish legal theory or on a close but ultimately unavailing one." *Neitzke v. Williams*, 490 U.S. 319, 327 (1989).

(citation and internal quotation omitted). A plaintiff who "alleges only an injury at some indefinite future time" has not shown an injury-in-fact, particularly where "the acts necessary to make the injury happen are at least partly within the plaintiff's own control." *Lujan*, 504 U.S. at 564 n.2. In these situations, "the injury [must] proceed with a high degree of immediacy, so as to reduce the possibility of deciding a case in which no injury would have occurred at all." *Id.*

The lead plaintiff, USCA, describes itself as a "national civic league" that is "devoted to the preservation of conservative values." SAC ¶ 12. But USCA does not assert any injury to itself as an organization; rather, it asserts that the minimum coverage provision will affect some of its members. *Id.* In order to assert associational standing, however, USCA must show that those members themselves have standing. *See Friends of the Earth, Inc. v. Laidlaw Envtl. Servs.*, 528 U.S. 167, 181 (2000). And it may not make generalized predictions that some unknown number of its members might have standing; instead, it must "make specific allegations establishing that at least one identified member [has] suffered or [will] suffer harm." *Summers v. Earth Island Inst.*, 129 S. Ct. 1142, 1151 (2009). The individual plaintiffs—Maurice Thompson and James Grapek—attempt to meet this burden by asserting that they are members of USCA, that they currently "do[] not have, and do[] not wish to acquire, any health insurance," and that they are not currently exempt from the minimum coverage provision. SAC ¶¶ 13-15. Mr. Thompson also alleges that he "has already begun consultations with insurance companies to determine his options under" the ACA. *Id.* ¶ 13. Mr. Grapek, for his part, alleges that he will "incur immediately foreseeable financial harm" under the ACA because he must "immediately begin saving thousands of dollars per year to afford premiums which will be required under" the minimum coverage

provision. *Id.* ¶ 14.

These allegations do not support standing in this case. As plaintiffs acknowledge, the minimum coverage provision will not take effect until January 1, 2014. *Id.*¶ 19. Even then, if plaintiffs are not exempted and elect not to purchase qualifying health insurance, any penalties would not be payable until their tax returns for that year are due, *i.e.*, April 2015. This alleged injury is "too remote temporally" to support standing. *See McConnell v. FEC*, 540 U.S. 93, 226 (2003) (Senator's claimed injury based on plans to air advertisements five years in the future was "too remote temporally" to sustain standing), *overruled in part on other grounds by Citizens United v. FEC*, 130 S. Ct. 876 (2010).

Plaintiffs reason that their injury is imminent because the minimum coverage provision is certain to go into effect in 2014. SAC ¶ 19. "These arguments, however, ignore the requirement of an injury in fact." *See Baldwin v. Sebelius*, No. 10-1033, 2010 WL 3418436, at *3. (S.D. Cal. Aug. 27, 2010) (dismissing a similar challenge to the ACA). The operation of the minimum coverage provision may be inevitable, but any harm to plaintiffs from its operation is not. Although plaintiffs object now to the ACA, they "cannot manufacture standing by withholding their consent to the law." *Id.*, 2010 WL 3418436, at *3.

Here, too, it is a matter of sheer speculation that plaintiffs will be injured by the minimum coverage provision in 2014 or 2015. Personal situations can change dramatically over three years. For example, an individual plaintiff "may take a job that offers health insurance, or qualify for Medicaid or Medicare, or he may choose to purchase health insurance before the effective date of the Act." *Id.* As events unfold, moreover, plaintiffs might qualify for one of the ACA's exemptions covering those who "cannot afford

coverage," or who would suffer hardship if required to purchase insurance. Pub. L. No 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(e)). "[I]t is impossible to know now whether or not Plaintiff[s] will be subject to or compliant with the Act in 2014." *Baldwin*, 2010 WL 3418436, at *3.[4]

Nor can plaintiffs Thompson and Grapek bootstrap an injury-in-fact by claiming that they have begun to prepare for the possibility that the minimum coverage provision will injure to them in 2014. First, these claimed injuries are unsubstantiated. The Secretary of Health and Human Services has not yet determined the criteria governing which health plans will be permitted to be certified as qualified health plans under the ACA. Therefore, it is unclear how Mr. Thompson could be presently consulting insurance companies about his insurance options in 2014.[5] It is also unclear how Mr. Grapek can know now that his premiums, if he is not exempted from the requirement altogether, will cost "thousands of dollars" in 2014, since it cannot be known that he will be subject to the Act at all. Such threadbare and conclusory allegations are "not entitled to be assumed true" and do not support standing. *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1951 (2009) (*citing Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 554-55 (2007)).

Furthermore, Mr. Grapek's asserted decision to save money cannot itself qualify as an imminent "injury." Until Mr. Grapek actually purchases health insurance or incurs a penalty

[4] The court in *Thomas More* erred in finding that the plaintiffs there had standing to challenge the provision because they are saving now to buy insurance in 2014. Slip op. at 7-8. As the *Baldwin* court correctly reasoned, if it cannot be known now whether plaintiffs will be subject to the Act in 2014, it also cannot be known now whether any planning efforts that they are taking now is traceable to the Act. *Baldwin*, 2010 WL 3418436, at *3.

[5] Furthermore, it is not clear how any "discussions" that Mr. Thompson chooses to have amount to an injury at all.

for failing to do so, he has not suffered a financial loss. *Cf. Miller v. Nissan Motor Acceptance Corp.*, 362 F.3d 209, 221-23 (3d Cir. 2004) (holding that the plaintiffs failed to allege a cognizable injury where they "never paid [an] early termination charge" and therefore "were not harmed by it," even if they had made the decision not to initiate early termination because of the lease provision that they sought to challenge).[6] At present, Mr. Grapek's choice to save money merely increases the amount of funds in his savings accounts. But the minimum coverage provision does not require him to take this, or any, action now.

2. Plaintiffs' Alleged Present Injury Is Not Fairly Traceable to the ACA

In addition to an injury-in-fact, plaintiffs must show their injury was caused by the challenged provision. *Lujan*, 504 U.S. at 560. "[A] causal connection between the injury and the conduct complained of—the injury has to be 'fairly . . . trace[able] to the challenged action of the defendant, and not . . . th[e] result [of] the independent action of some third party not before the court.'" *Id.* (citing *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 41-42 (1976). Specifically, "the chain of causation between the challenged Government conduct and the asserted injury" must "as a whole . . . sustain [plaintiffs'] standing. *Allen v. Wright*, 468 U.S. 737, 759 (1984).

Even if Mr. Thompson's and Mr. Grapek's alleged current preparatory steps amounted to an injury, they are not fairly traceable to the ACA. To the extent that their preparations for 2014 constitute an injury at all, it "stems not from the operation of [the challenged statute] but from [plaintiffs'] own . . . personal wish." *See McConnell*, 540 U.S.

[6] *See also Fair Emp't Council of Greater Wash. v. BMC Mktg. Corp.*, 28 F.3d 1268, 1277 (D.C. Cir. 1994).

at 228; *see also Utah Shared Access Alliance v. Carpenter*, 463 F.3d 1125, 1137-38 (10th Cir. 2006), *cert. denied*, 550 U.S. 904 (2007); *Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 831 (D.C. Cir. 2006). Whether to discuss potential insurance options and whether to budget for future contingencies are within plaintiffs' discretion. Nothing in the ACA requires them to do anything now. Furthermore, Mr. Grapek's decision to save in anticipation of future budgetary needs is not "traceable" to the ACA, as this Court "simply will not be able to determine whether" the ACA caused such action. *Sanner v. Bd. of Trade of City of Chi.*, 62 F.3d 918, 924 (7th Cir. 1995). "[A] host of articulable and inatriculable reasons" may lead Mr. Grapek to choose "*not* to purchase" other things to amass savings now. *Id.* at 923-24

To hold that Mr. Thompson's and Mr. Grapek's independent calculations in the present could satisfy "causation" would gut the doctrine of standing. Such a holding would enable all would-be plaintiffs to sue based on the most remote and unlikely contingencies, because they have currently decided to take steps in anticipation of those future possibilities. Many uncertainties remain: what the future cost of health insurance will be, what plaintiffs future health care needs will be, whether plaintiffs' will be unable to "afford coverage" in 2014, whether purchasing insurance would cause financial hardship to plaintiffs, and whether plaintiffs will qualify for one of the Act's exemptions, Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(d), (e)). Mr. Thompson's and Mr. Grapek's decisions to address future contingencies now are their own, and do not create an injury traceable to the ACA.

If, come 2014, plaintiffs have not satisfied the minimum coverage provision and choose not to purchase health insurance, they can pay the resulting penalty and challenge the provision in a suit for a refund. As of now, however, plaintiffs cannot demonstrate their

standing by pleading that they *currently* do not wish to obtain insurance, that they *currently* do not qualify for one of the exceptions to the minimum coverage provision, or that they are *currently* planning or budgeting for health insurance in the future. Any harm that plaintiffs might suffer is remote rather than imminent, speculative rather than concrete, and "at least partly within [their] own control." *Lujan*, 504 U.S. at 564 n.2. Plaintiffs therefore lack standing. *See, e.g.*, *Rosen*, 288 F.3d at 929 (rejecting plaintiffs' argument that "[s]ince they . . . will potentially be affected by [the statute] in the future, . . . they ha[d] the requisite personal stake in its implementation now").[7]

B. Plaintiffs' Claims Are Unripe

For similar reasons, plaintiffs' challenge to the minimum coverage provision is not ripe for review. The ripeness inquiry "evaluate[s] both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." *Abbott Labs. v. Gardner*, 387 U.S. 136, 149 (1967). Plaintiffs' challenge satisfies neither prong of the ripeness inquiry because no injury could occur before 2014, and plaintiffs cannot show that one will occur even then. *See Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985) (claim is not ripe if it rests upon "contingent future events that may not occur as anticipated, or indeed may not occur at all") (citation and internal quotation omitted); *Grand Lodge of Fraternal Order of Police v. Ashcroft*, 185 F. Supp. 2d 9, 17-18 (D.D.C. 2001) ("[W]ith respect to the 'hardship to the parties' prong, an abstract harm is not

[7] Plaintiffs also assert that they have standing because they will "suffer . . . from a transformation of the medical marketplace affected by changes in health care delivery, service, and cost effected by the PPACA." SAC ¶ 20. They do not plead with specificity how they will be harmed by this "transformation." In any event, this assertion is a "generalized grievance," not a claim of injury that is concrete and particularized to these plaintiffs. *See Wuliger v. Manufacturers Life Insurance Co.*, 567 F.3d 787, 793 (6th Cir. 2009).

sufficient; there must be an immediate harm with a 'direct effect on the day-to-day business of the plaintiffs.'") (quoting *Texas v. United States*, 523 U.S. 296, 301 (1998)); *see also Ammex, Inc. v. Cox*, 351 F.3d 697, 701 (6th Cir. 2003).

To be sure, "[w]here the inevitability of the operation of a statute against certain individuals is patent, it is irrelevant to the existence of a justiciable controversy that there will be a time delay before the disputed provisions will come into effect." *Blanchette v. Conn. Gen. Ins. Corp.*, 419 U.S. 102, 143 (1974). However, as explained *supra* at pages 11-14, any injury to plaintiffs here is far from "inevitabl[e]." Nor is this a case like *Abbott Laboratories*, where the plaintiffs demonstrated "a direct effect on [their] day-to-day business." 387 U.S. at 152. This case instead involves "contingent future events that may not occur as anticipated, or indeed may not occur at all." *Thomas*, 473 U.S. at 580-81. Even where the issue presented is "a purely legal question," such uncertainty whether a statutory provision will harm the plaintiffs renders the controversy not ripe for review. *Toilet Goods Ass'n v. Gardner*, 387 U.S. 158, 163-64 (1967).[8]

C. The Anti-Injunction Act Bars Plaintiffs' Claims

Even if plaintiffs had an injury-in-fact and presented a ripe claim, the Anti-Injunction Act ("AIA"), 26 U.S.C. § 7421(a), would bar their claim for relief. Plaintiffs note that they would "face a tax penalty" under the minimum coverage provision if they do not obtain qualified coverage. SAC ¶ 20. Plaintiffs' claims by their terms fall within the AIA, which

[8] The court in *Thomas More* found the case before it to be ripe because "the imposition" of the minimum coverage provision "is highly probable." Slip op. at 9. But the question is not whether the statute is certain to go into effect; instead, the question is whether the provision is certain to operate to the detriment of the plaintiffs here. As noted above, it cannot be known now whether the plaintiffs here will be subject to the Act, or whether they will in fact benefit from it, for example, if they develop pre-existing medical conditions, which would render them uninsurable in the absence of the Act.

provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. § 7421(a).

Even if plaintiffs did not so explicitly lodge their claims within the purview of the Anti-Injunction Act, that statute would still bar the relief they seek. Whether or not the penalty here is labeled a tax, it is, with exceptions not material here, "assessed and collected in the same manner" as other penalties under the Internal Revenue Code, Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(g)(1)), and, like these other penalties, it is covered by the AIA. 26 U.S.C. § 6671(a); *see, e.g.*, *Barr v. United States*, 736 F.2d 1134, 1135 (7th Cir. 1984) (per curiam) ("Section 6671 provides that the penalty at issue here is a tax for purposes of the Anti-Injunction Act."). That result is consistent with the purpose of the AIA, which is to preserve the Government's ability to collect such assessments expeditiously with "a minimum of preenforcement judicial interference" and "to require that the legal right to the disputed sums be determined in a suit for refund." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 736 (1974) (citation and internal quotation omitted).

Under the AIA, as well as the Declaratory Judgment Act,[9] district courts lack jurisdiction to order the abatement of any such liability under the Internal Revenue Code except in valid claims for refund. *See Bartley v. United States*, 123 F.3d 466, 467 (7th Cir.

[9] The Declaratory Judgment Act, 28 U.S.C. § 2201(a), similarly provides district courts the jurisdiction to grant declaratory relief "except with respect to Federal taxes." As the Supreme Court noted in *Bob Jones University*, the tax exception to the Declaratory Judgment Act demonstrates the "congressional antipathy for premature interference with the assessment or collection of any federal tax." 416 U.S. at 732 n.7. The scope of the tax exception under § 2201 is "at least as broad" as the AIA. *Id.*

1997). And the AIA is "not limited to suits aimed at the specific act of assessment or collection." *Dickens v. United States*, 671 F.2d 969, 971 (6th Cir. 1982). Instead, the statute bars any injunction that "would necessarily preclude" the collection of taxes. *Bob Jones Univ.*, 416 U.S. at 731-32; *see also Ecclesiastical Order of the ISM of AM, Inc. v. IRS*, 725 F.2d 398, 401 (6th Cir. 1984); *Dickens*, 671 F.2d at 971. *See generally Hansen v. Dep't of Treasury*, 528 F.3d 597, 601-02 (9th Cir. 2007).

These jurisdictional limitations apply even where, as here, plaintiffs raise a constitutional challenge to a statute that imposes a penalty:

> The "decisions of this Court make it unmistakably clear that the constitutional nature of a taxpayer's claim . . . is of no consequence" to whether the prohibition against tax injunctions applies. This is so even though the Anti-Injunction Act's prohibitions impose upon the wronged taxpayer requirements at least as onerous as those mandated by the refund scheme—the taxpayer must succumb to an unconstitutional tax, and seek recourse only after it has been unlawfully exacted.

United States v. Clintwood Elkhorn Mining Co., 553 U.S. 1, 10 (2008) (quoting *Alexander v. "Americans United" Inc.*, 416 U.S. 752, 759 (1974)).

Plaintiffs seek declaratory and injunctive relief that would necessarily preclude the federal government from assessing or collecting the penalty that takes effect in 2014 if an individual fails to obtain minimum coverage. The AIA, therefore, bars subject matter jurisdiction over plaintiffs' suit.[10]

[10] The court in *Thomas More* reasoned that the AIA did not apply, because the plaintiffs had brought suit before the IRS had begun assessment or collection efforts, because the suit sought only declaratory relief, and because the case raised constitutional issues. Slip op. at 10-11. But, as noted above: (1) the AIA extends beyond suits that specifically challenge assessment or collection efforts, and instead bars any suit that could have the effect of precluding a tax, *see Dickens*, 671 F.2d at 971; (2) the Declaratory Judgment Act bars declaratory relief as least as broadly as the AIA bars injunctive relief, *see* note 9 above; and (3) the constitutional nature of a claim is irrelevant for purposes of the AIA, *see Clintwood*

II. THE MINIMUM COVERAGE PROVISION FALLS WITHIN CONGRESS'S CONSTITUTIONAL AUTHORITY

Even if this Court had subject matter jurisdiction over plaintiffs' challenges to the minimum coverage provision, the challenges would fail on the merits. "'[D]ue respect for the decisions of a coordinate branch of Government demands that [this Court] invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds.'" *United States v. Ostrander*, 411 F.3d 684, 694 (6th Cir. 2005) (quoting *United States v. Morrison*, 529 U.S. 598, 607 (2000)). Moreover, in presenting a facial challenge to a federal statute, as plaintiffs do here, a plaintiff may prevail only "by 'establish[ing] that no set of circumstances exists under which the Act would be valid,' *i.e.*, that the law is unconstitutional in all of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (quoting *United States v. Salerno*, 481 U.S. 739, 745 (1987)); *see also Nebraska v. EPA*, 331 F.3d 995, 998 (D.C. Cir. 2003) (rejecting facial Commerce Clause challenge to federal statute); *United States v. Sage*, 92 F.3d 101, 106 (2d Cir. 1996) (same). Plaintiffs can make no such showing.

A. The Comprehensive Regulatory Measures of the ACA, Including the Minimum Coverage Provision, Are a Proper Exercise of Congress's Powers Under the Commerce Clause and the Necessary and Proper Clause

Plaintiffs assert that the minimum coverage provision exceeds Congress's authority under the Commerce Clause. SAC ¶¶ 34-40. That claim is mistaken. First, the provision regulates *economic* decisions regarding the way in which health care services are paid for—decisions that, in the aggregate, have a direct and substantial effect on interstate commerce. *See Thomas More*, slip op. at 16-17. Second, Congress had far more than a rational basis to

---

Elkhorn, 553 U.S. at 10.

find that the provision is an essential element of the ACA's larger, unchallenged effort to regulate the interstate business of health insurance. The provision prohibits participants in the health care market from shifting the costs of their care to third parties and prevents individuals from relying on the ACA's insurance reforms (*e.g.*, the ban on denying coverage to or charging more for people with pre-existing medical conditions) to delay buying health insurance until illness strikes or accident occurs. *See id.*, slip op. at 18. In short, based on detailed congressional findings, which were the product of extensive hearings and debate, the provision directly addresses cost-shifting in those markets, quintessentially economic activity, and it forms an essential part of a comprehensive, interrelated regulatory scheme. Moreover, in focusing on the health care services market, in which virtually everyone participates at some point, and regulating the economic decision whether to pay for health care in advance through insurance or to try (often unsuccessfully) to pay later out-of-pocket, the provision falls within Congress's authority to regulate interstate commerce. And because the provision is reasonably adapted as a means to accomplish the ends of the ACA, it is well within Congress's authority under the Necessary and Proper Clause.

1. Congress's Authority to Regulate Interstate Commerce Is Broad

The Constitution grants Congress the power to "regulate Commerce . . . among the several States," U.S. CONST. Article I, Section 8, Clause 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id.*, Clause 18. This authority is broad. Congress may "regulate the channels of interstate commerce"; it may "regulate and protect the instrumentalities of interstate commerce, and persons or things in interstate commerce"; and it may "regulate activities that substantially affect interstate commerce." *Raich*, 545 U.S. at 16-17. In assessing whether an activity substantially affects interstate

commerce, Congress may consider the aggregate effect of a particular form of conduct. The question is not whether any one person's conduct, considered in isolation, affects interstate commerce, but whether there is a rational basis for concluding that the *class of activities*, "taken in the aggregate," has at least some substantial effect on interstate commerce. *Id.* at 22; *see also Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942). In other words, "'[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances' of the class." *Raich*, 545 U.S. at 23 (quoting *Perez v. United States*, 402 U.S. 146, 154 (1971)); *see also United States v. Bowers*, 594 F.3d 522, 528 (6th Cir. 2010).

In exercising its Commerce Clause power, Congress may also reach even wholly intrastate, non-commercial matters when it concludes that failure to do so would undercut the operation of a larger program regulating interstate commerce. *Raich*, 545 U.S. at 18. Thus, when "a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence." *Id*. at 17 (citation and internal quotation omitted); *see also id.* at 37 (Scalia, J., concurring in the judgment) (Congress's authority to make its regulation of commerce effective is "distinct" from its authority to regulate matters that substantially affect interstate commerce); *Bowers*, 594 F.3d at 529; *United States v. Rose*, 522 F.3d 710, 719 (6th Cir. 2008).

In assessing these congressional judgments regarding the impact on interstate commerce and the necessity of individual provisions to the overall scheme of reform, the task of this Court "is a modest one." *Raich*, 545 U.S. at 22. The Court need not itself measure the impact on interstate commerce of the activities Congress sought to regulate. Nor need the Court calculate how integral a particular provision is to a larger regulatory

program. The Court's task instead is to determine "whether a 'rational basis' exists" for Congress's conclusions. *Id.* (quoting *United States v. Lopez*, 514 U.S. 549, 557 (1995)); *see also Norton v. Ashcroft*, 298 F.3d 547, 555 (6th Cir. 2002). Under rational basis review, this Court may not second-guess the factual record upon which Congress relied.[11]

Raich and *Wickard* illustrate the breadth of the Commerce power and the deference accorded Congress's judgments. In *Raich*, the Court sustained Congress's authority to prohibit the possession of home-grown marijuana intended solely for personal use. It was sufficient that the Controlled Substances Act "regulates the production, distribution, and consumption of commodities for which there is an established, and lucrative, interstate market." 545 U.S. at 26. In *Wickard*, the Court upheld a penalty on wheat grown for home consumption despite the farmer's protests that he did not intend to put the commodity on the market. It was sufficient that the existence of homegrown wheat, in the aggregate, could "suppl[y] a need of the man who grew it which would otherwise be reflected by purchases in the open market," thus undermining the efficacy of the federal price stabilization scheme. 317 U.S. at 128. In each case, the Court upheld obligations even on individuals who claimed not to participate in interstate commerce, because those obligations were components of broad schemes regulating interstate commerce.

Raich followed *Lopez*, 514 U.S. 549, and *Morrison*, 529 U.S. 598, and thus highlights the central focus and limited scope of those decisions. Unlike *Raich*, and unlike this case, neither *Lopez* nor *Morrison* involved regulation of economic decisions. Neither case addressed a measure integral to a comprehensive scheme to regulate activities in interstate

[11] "[L]egislative facts," Fed. R. Evid. 201 advisory comm. note, may be considered on a motion to dismiss. *See Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007).

commerce. *Lopez* was a challenge to the Gun-Free School Zones Act of 1990, "a brief, single-subject statute making it a crime for an individual to possess a gun in a school zone." *Raich*, 545 U.S. at 23. Possessing a gun in a school zone "had nothing to do with" any economic decision. *Lopez*, 514 U.S. at 561. Nor was it "'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.'" *Raich*, 545 U.S. at 24 (quoting *Lopez*, 514 U.S. at 561). Indeed, the argument that this provision affected interstate commerce had to posit an extended chain reaction—guns near schools lead to violent crime; such violent crime imposes costs; and insurance spreads those costs. The Court found this reasoning too attenuated to sustain the gun law "'under [the Court's] cases upholding regulations of activities that arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce.'" *Id.* (quoting *Lopez*, 514 U.S. at 561). Likewise, the statute at issue in *Morrison* simply created a civil remedy for victims of gender-motivated violent crimes. *Id.* at 25. Unlike the purchase of health care services or health insurance, gender-motivated violent crimes do not entail economic decisions, and the statute at issue was not part of any broader regulation of interstate markets.

2. The ACA, and the Minimum Coverage Provision, Regulate the Interstate Market in Health Insurance

Regulation of a vast interstate market that consumes more than an estimated 17.5% of our gross domestic product is well within the compass of congressional authority under the Commerce Clause. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a). It has long been established that Congress has power to regulate the interstate health insurance market, *see United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 553 (1944), and Congress

has repeatedly exercised that power, both by providing directly for government-funded health insurance through government programs such as Medicare, and by adopting over the course of four decades numerous statutes that regulate the content of policies offered by private insurers.[12]

This history of federal regulation of health insurance buttressed Congress's understanding that only it, and not the states, could effectively counter the national health care crisis. Given the current scope of federal regulation—for example, through Medicare and ERISA—"[e]xpecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort." *State Coverage Initiatives: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Cong. 7 (2008) (Alan R. Weil, Executive Director, National Academy of State Health Policy). Moreover, reform at the national level avoids the complexities, and

[12] In 1974, Congress enacted the Employee Retirement and Income Security Act, Pub L. No. 93-406, 88 Stat. 829 ("ERISA"), establishing federal requirements for health insurance plans offered by private employers. Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 ("COBRA"), allowing workers who lose their health benefits under certain circumstances the right to continue receiving certain benefits from their plans for a time. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 ("HIPAA"), to improve access to health insurance by, among other things, generally prohibiting group plans from discriminating against individual participants based on health status, requiring insurers to offer coverage to small businesses, and limiting the pre-existing condition exclusion period for group plans. 26 U.S.C. §§ 9801-03; 29 U.S.C. §§ 1181(a), 1182; 42 U.S.C. §§ 300gg, 300gg-1. *See generally* Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (regulating limits on mental health benefits); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (requiring plans that offer maternity coverage to provide at least a 48-hour hospital stay following childbirth); Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 (requiring certain plans to offer benefits related to mastectomies). More recently, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881, requiring parity in financial requirements and treatment limitations between mental health and substance use disorder benefits and medical and surgical benefits.

thus the costs, that inevitably result from a reliance on a patchwork of state health insurance regulations. *Id.* at 28 (statement of Trish Riley, Director, Maine Governor's Office of Health Policy & Finance).

Accordingly, Congress undertook in the ACA comprehensive reform of the interstate health insurance market. To regulate health insurance provided through the workplace, the ACA adopts incentives for small employers to offer or expand health insurance coverage. To regulate health insurance provided through government programs, the ACA, among other things, expands Medicaid eligibility. To regulate health insurance sold to individuals or in small group markets, the ACA establishes health insurance Exchanges enabling individuals and small businesses to pool their purchasing power and obtain affordable insurance. And to regulate the overall scope of health insurance coverage, the ACA extends tax credits to a significant portion of the uninsured; ends industry practices that have made insurance unobtainable or unaffordable for many; and, in § 1501, requires non-exempt Americans who can afford insurance to obtain a minimum level of coverage or to pay a penalty.

Section 1501 regulates decisions about how to pay for services in the health care market. These decisions are quintessentially economic, and within the traditional scope of the Commerce Clause. As Congress recognized, "decisions about how and when health care is paid for, and when health insurance is purchased" are "economic and financial" and thus "commercial and economic in nature." Pub. L. No. 111-148, §§ 1501(a)(2)(A), 10106(a); *see Thomas More*, slip op. at 16 (recognizing these decisions as "plainly economic").[13]

[13] Although Congress is not required to set forth particularized findings of an activity's effect on interstate commerce, when, as here, it does so, courts "will consider congressional findings in [their] analysis." *Raich*, 545 U.S. at 21.

3. The Minimum Coverage Provision Is an Integral Part of the Larger Regulatory Scheme, and Is Necessary and Proper to Congress's Regulation of Interstate Commerce

The ACA's reforms of the interstate insurance market—particularly its requirement that insurers guarantee coverage even for those with pre-existing medical conditions—could not function without the minimum coverage provision. The provision is essential to a larger regulation of interstate commerce, and thus, under *Raich*, is within Congress's Commerce Clause authority. *Raich*, 545 U.S. at 18; *see also Rose*, 522 F.3d at 719. Analyzing the minimum coverage provision under the Necessary and Proper Clause leads to the same conclusion for fundamentally the same reason. The provision is a reasonable means to accomplish Congress's goal of ensuring affordable coverage for all Americans.

The minimum coverage provision is an essential part of the ACA's larger regulatory scheme for the interstate health care market. As explained above, the ACA adopts a series of measures to increase the availability and affordability of health insurance, including, in particular, measures to prohibit insurance practices that have denied coverage or have increased premiums for those with the greatest health care needs. Beginning in 2014, the ACA will bar insurers from refusing to cover or charging more for individuals with pre-existing medical conditions, and from setting eligibility rules based on health status, medical condition, claims experience, or medical history. Pub. L. No. 111-148, § 1201. These provisions, which directly regulate the content of insurance policies sold nationwide, are clearly within the Commerce Clause power. *See, e.g., S.E. Underwriters Ass'n*, 322 U.S. at 553.[14]

[14] The McCarran Ferguson Act, 15 U.S.C. §§ 1011-1015, does not change this conclusion. That Act exempts the business of insurance from federal regulation except when

Congress found that, absent the minimum coverage provision, these insurance reforms would encourage more individuals to "wait to purchase health insurance until they needed care"—at which point the ACA would obligate insurers to cover them at the same cost as everyone else. Pub. L. No. 111-148, §§ 1501(a)(2)(I), 10106(a). This market distortion would make insurance *less* affordable for everyone, *decrease* the number of insured individuals, and create pressures that would "inexorably drive [the health insurance] market into extinction." *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. 13 (2009) (statement of Uwe Reinhardt, Ph.D., Professor, Princeton University) [hereinafter *Health Reform in the 21st Century*].[15] Accordingly, Congress found the minimum coverage provision to be "essential" to its broader effort to regulate health insurance industry practices that have prevented many from obtaining health insurance. Pub. L. No. 111-148, §§ 1501(a)(2)(H), (I), 10106(a).

In other respects, the minimum coverage provision is essential to the Act's comprehensive scheme to ensure that health insurance coverage is available and affordable. The provision works in tandem with the Act's reforms to reduce the upward pressure on

---

a federal law "specifically relates to the business of insurance." 15 U.S.C. § 1012(b). It is beyond question that the ACA, which enacts comprehensive reforms of the health insurance business, "specifically relates to the business of insurance."

[15] *See also Health Reform in the 21st Century*, at 101-02; *id.* at 123-24 (National Association of Health Underwriters) (observing, based on the experience of "states that already require guaranteed issue of individual policies, but do not require universal coverage," that "[w]ithout near universal participation, a guaranteed-issue requirement . . . would have the perverse effect of encouraging individuals to forego buying coverage until they are sick or require sudden and significant medical care"); Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, HEALTH AFFAIRS, July/Aug. 2004, at 167, 168 (describing the mechanics of an "adverse-selection death spiral" in a market with no exclusions, no individual premium adjustments, and no minimum coverage requirement) (cited in *Health Reform in the 21st Century*, at 13 n.4 (statement of Dr. Reinhardt)).

premiums caused by current underwriting practices. CBO, KEY ISSUES, at 81. This individualized review of an applicant's health status inflates the administrative fees comprising 26% to 30% of premiums in the individual and small group markets. Pub. L. No. 111-148, §§ 1501(a)(2)(J), 10106(a). "By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of [the ACA], will significantly reduce administrative costs and lower health insurance premiums," and is therefore "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." *Id.* §§ 1501(a)(2)(J), 10106(a).

Congress thus found that failure to regulate the decision to forgo insurance—*i.e.*, the decision to shift costs to the larger health care system—would undermine the ACA's comprehensive regulatory regime. It accordingly had ample basis to conclude that not regulating this "class of activity" would "undercut the regulation of the interstate market" in health insurance, thereby justifying its exercise of the commerce power to enact the provision. *Raich*, 545 U.S. at 18; *see id.* at 37 (Scalia, J., concurring in the judgment) ("Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce."); *see also Thomas More*, slip op. at 18 (recognizing that the minimum coverage provision "operates as an essential part of a comprehensive regulatory scheme" and thus is valid under *Raich*).

Because the minimum coverage provision is essential to Congress's overall regulatory reform of the interstate health care and health insurance markets, it is also plainly a valid exercise of Congress's authority under the Necessary and Proper Clause, U.S. CONST. art. I, § 8, cl. 18. "[T]he Necessary and Proper Clause grants Congress broad authority to enact

federal legislation." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010). It has been settled since *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819), that this clause affords Congress the power to employ any means "reasonably adapted to the end permitted by the Constitution." *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276 (1981) (citation and internal quotation omitted). And when Congress legislates in furtherance of a legitimate end, its choice of means is accorded broad deference. *See Sabri v. United States*, 541 U.S. 600, 605 (2004); *see also Comstock*, 130 S. Ct. at 1956-57. "[W]here Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)).

As Congress found, the minimum coverage provision not only is "reasonably adapted," but indeed is "essential," to achieving key reforms of the interstate health insurance market. As noted, the ACA bars insurers from denying coverage or charging higher rates based on medical conditions, including pre-existing conditions. Congress plainly has the power under the Commerce Clause to impose these requirements; indeed, they are consistent with decades of Congressional regulation of private insurers. *See supra* note 12. Without the minimum coverage provision, healthy individuals would have overwhelmingly strong incentives to forgo insurance coverage, knowing that the new reforms guarantee that they could obtain coverage later if and when they become ill. As a result, the cost of insurance would skyrocket, and the larger system of reforms would fail. *See, e.g.*, *Health Reform in the 21st Century*, at 13. Congress thus had far more than a rational basis to conclude that the minimum coverage provision is necessary to make the other regulations in the ACA effective. The provision is, therefore, easily justified under the

Necessary and Proper Clause. *See Comstock*, 130 S. Ct. at 1957 ("'If it can be seen that the means adopted are really calculated to attain the end, the degree of their necessity, the extent to which they conduct to the end, the closeness of the relationship between the means adopted and the end to be attained, are matters for congressional determination alone.'") (quoting *Burroughs v. United States*, 290 U.S. 534, 547-48 (1934)).

4. The Minimum Coverage Provision Regulates Conduct with Substantial Effects on Interstate Commerce

The minimum coverage provision is a valid exercise of Congress's Article I powers for a second reason. Congress needed no extended chain of inferences to determine that decisions about how to pay for health care—particularly decisions about whether to obtain health insurance or to attempt to pay for health care out-of-pocket—in the aggregate substantially affect the interstate health care market. Individuals who forgo health insurance coverage do not thereby forgo health care. To the contrary, many of the uninsured will "receive treatments from traditional providers for which they either do not pay or pay very little, which is known as 'uncompensated care.'" CBO, KEY ISSUES, at 13; *see also* COUNCIL OF ECONOMIC ADVISERS ("CEA"), THE ECONOMIC CASE FOR HEALTH CARE REFORM 8 (2009) [hereinafter THE ECONOMIC CASE] (submitted into the record for *The Economic Case for Health Reform: Hearing Before the H. Comm. on the Budget*, 111th Cong. 5 (2009)). In this country, a minimum level of health care is effectively guaranteed. Under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, for example, hospitals that participate in Medicare and offer emergency services are required to screen and stabilize any patient who arrives with an emergency condition, regardless of insurance coverage or ability to pay. CBO, KEY ISSUES, at 13. In addition, most hospitals are nonprofit organizations

with an "obligation to provide care for free or for a minimal charge to members of their community who could not afford it otherwise." *Id.* For-profit hospitals "also provide such charity or reduced-price care." *Id.*

"Uncompensated care," of course, is not free. In the aggregate, it cost $43 billion in 2008, about 5% of hospital revenues. CBO, KEY ISSUES, at 114; *see also* Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a). These costs are subsidized by public funds, including tens of billions of federal dollars in 2008 alone. H.R. Rep. No. 111-443, pt. II, at 983 (2010); *see also* THE ECONOMIC CASE, at 8. The remaining costs are borne in the first instance by health care providers, which in turn "pass on the cost to private insurers, which pass on the cost to families." Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a). This cost-shifting creates a "hidden tax" reflected in fees charged by health care providers and premiums charged by insurers. CEA, ECONOMIC REPORT OF THE PRESIDENT 187 (Feb. 2010); *see also* H.R. Rep. No. 111-443, pt. II, at 985 (2010); S. Rep. No. 111-89, at 2 (2009).

Furthermore, as premiums increase, more people decide not to buy coverage. This self-selection further narrows the risk pool, forcing upward the price of coverage even more for those who are insured. The result is a self-reinforcing "premium spiral." *Health Reform in the 21st Century*, at 118-19 (statement of The American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at 985 (2010). This "premium spiral" particularly harms small employers, due to their relative lack of bargaining power. *See* H.R. Rep. No. 111-443, pt. II, at 986-88 (2010); *see also 47 Million & Counting: Why the Health Care Market Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. 36 (2008) (statement of Raymond Arth, President & CEO, Phoenix Products, Inc.).

The putative right to forgo health insurance which plaintiffs champion includes

decisions by some to engage in market timing. They will purchase insurance in later years, but choose in the short term to incur out-of-pocket costs with the safety net of emergency room services that most hospitals must provide whether or not the patient can pay. *See* CBO, KEY ISSUES, at 12 (percentage of uninsured older adults in 2007 was roughly half that of younger adults). By making the economic calculation to opt out of health insurance during these years, these individuals skew premiums upward for the insured population. Yet, when they need care, many of these uninsured opt back into the health insurance system maintained in the interim by an insured population that has borne the costs of uncompensated care. In the aggregate, these economic decisions regarding how to pay for health care—including, in particular, decisions to forgo coverage and to pay later or, if need be, to depend on free care—substantially affect the interstate health care market. Congress may use its Commerce Clause authority to address these direct and aggregate effects. *See Raich*, 545 U.S. at 16-17; *Wickard*, 317 U.S. at 127-28.

Plaintiffs cannot brush aside these marketplace realities with the simple assertions that the uninsured "do not engage in activities that substantially affect interstate commerce," SAC ¶ 37, or that the choice to forgo insurance is "citizen inactivity [that] would have no bearing on the interstate market," SAC ¶ 39. Those assertions misunderstand both the nature of the regulated activity here, the scope of Congress's power, and the precedent in this Circuit, which specifically rejects the distinction that plaintiffs advance.

Congress found that the decision to try to pay for health care services without reliance on insurance is "economic and financial." Pub. L. No. 111-148,§§ 1501(a)(2)(A), 10106(a). Indeed, that is precisely how USCA portrays its members' decisions to forgo insurance. SAC ¶ 27 ("[Members] variously wish to save, invest, or otherwise expend the thousands of

dollars each year . . . ."). Individuals who make that economic choice have not opted out of health care; they are not passive bystanders divorced from the health care market. To the contrary, "[n]o one can guarantee his or her health, or ensure that he or she will never participate in the health care market." *Thomas More*, slip op. at 16. Indeed, far from being inactive bystanders, the vast majority of the population—even of the uninsured population—has participated in the health care market by receiving medical services. *See* JUNE E. O'NEILL & DAVE M. O'NEILL, EMP. POLICIES INST., WHO ARE THE UNINSURED?: AN ANALYSIS OF AMERICA'S UNINSURED POPULATION, THEIR CHARACTERISTICS, AND THEIR HEALTH 20-22 (2009) (94% of even long-term uninsured have received some level of medical care). Nor do these individuals sit passively even with respect to insurance coverage. Instead, movement in and out of insured status is "very fluid." CBO, HOW MANY PEOPLE LACK HEALTH INSURANCE AND FOR HOW LONG? 4 (May 2003). Of those who are uninsured at some point in a given year, about 63% have coverage at some other point during the same year. *Id.* at 4, 9. These persons make the decisions to add or drop coverage knowing that they will not bear the full cost of their decision to attempt to pay for their health care needs out-of-pocket. THE ECONOMIC CASE, at 17; *see also* Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. OF HEALTH ECON. 225, 226 (2005). Notwithstanding plaintiffs' attempt to characterize those economic decisions as "inactivity," they have a direct and substantial effect on the interstate health care market in which uninsured and insured alike participate, and thus are subject to federal regulation.

The ACA in fact regulates economic activity far more directly than other provisions that the Supreme Court and the Sixth Circuit have upheld. In *Wickard*, for example, the

Court upheld a system of production quotas against the plaintiff farmer's claim that the statute required him to purchase wheat on the open market rather than grow it himself. The Court reasoned that "[h]ome-grown wheat in this sense competes with wheat in commerce. The stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon." 317 U.S. at 128; *see id.* at 127 (sustaining law restricting "the amount which may be produced for market *and the extent as well to which one may forestall resort to the market* by producing to meet his own needs" (emphasis added)); *see also Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258-59 (1964) (Commerce Clause reaches decisions *not to engage* in transactions with persons with whom plaintiff did not wish to deal); *Daniel v. Paul*, 395 U.S. 298 (1969) (same). And in *Raich*, the Court likewise rejected the plaintiffs' claim that their home-grown marijuana was "entirely separated from the market" and thus not subject to regulation under the Commerce Clause. 545 U.S. at 30. These decisions establish that "[t]he Supreme Court has consistently rejected claims that individuals who choose not to engage in commerce thereby place themselves beyond the reach of the Commerce Clause." *Thomas More*, slip op. at 17.

In light of these authorities, plaintiffs' attempt to characterize their behavior as "inactivity" beyond the reach of the Commerce Clause is unavailing. The Sixth Circuit rejected the identical claim in *United States v. Faasse*, 265 F.3d 475 (6th Cir. 2001) (en banc). That case concerned a challenge to the Child Support Recovery Act, which regulates the failure to send child support payments. The defendant there, like the plaintiffs here, contended that his behavior was passive and thus beyond Congress's Article I powers. The court expressly rejected the defendant's proffered distinction between activity and inactivity:

> [I]t is immaterial that the CSRA regulates a defendant's failure to put a thing

> in commerce. It is true that many federal statutes prohibit, rather than seek to compel, goods or services from passing through interstate commerce. . . . As the Fifth Circuit noted, however, "[t]he Supreme Court has often held, in several contexts, that the defendant's nonuse of interstate channels alone does not shield him from federal purview under the Commerce Clause."

Faasse, 265 F.3d at 486 (quoting *United States v. Bailey*, 115 F.3d 1222, 1229-30 (5th Cir. 1997)); *see also id.* at 487 (rejecting claim that defendant "passively failed to engage in commerce"). Similarly, the ACA regulates a class of individuals who already are participants in the health care market, who choose to finance that participation in one particular way, and whose decisions impose substantial costs on other participants in that market. *See Thomas More*, slip op. at 16-17 (recognizing that no person can "ensure that he or she will never participate in the health care market" and that the minimum coverage provision simply addresses how participants in that market pay for the services that they receive). Given the substantial effects of these economic decisions on interstate commerce, Congress has authority to regulate.

B. The Minimum Coverage Provision Is a Valid Exercise of Congress's Independent Power Under the General Welfare Clause

Plaintiffs' challenge fails for an additional reason. Independent of the Commerce Clause, Congress has the "Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. CONST. art. I, § 8, cl. 1. Congress's power to collect revenue and make expenditures under the General Welfare Clause is "extensive." *License Tax Cases*, 72 U.S. (5 Wall.) 462, 471 (1867); *see also McCray v. United States*, 195 U.S. 27, 56-59 (1904); *United States v. Doremus*, 249 U.S. 86, 93 (1919); *Steward Machine Co. v. Davis*, 301 U.S. 548, 581 (1937). Congress may use this authority even for purposes beyond its powers under

other provisions of Article I. *See United States v. Sanchez*, 340 U.S. 42, 44 (1950) ("Nor does a tax statute necessarily fall because it touches on activities which Congress might not otherwise regulate."); *Knowlton v. Moore*, 178 U.S. 41, 59-60 (1900) (Congress may tax inheritances, even if it may not regulate them under the Commerce Clause).

To be sure, Congress must use its power under Article I, Section 8, Clause 1, to "provide for the . . . general Welfare." As the Supreme Court held 75 years ago with regard to the Social Security Act, however, decisions about how best to provide for the general welfare are for the representative branches, not for the courts. *Helvering v. Davis*, 301 U.S. 619, 640, 645 & n.10 (1937); *see also South Dakota v. Dole*, 483 U.S. 203, 207 (1987); *Cutter v. Wilkinson*, 423 F.3d 579, 585 (6th Cir. 2005).

The minimum coverage provision falls within Congress's "extensive" General Welfare authority. *License Tax Cases*, 72 U.S. at 471. Congress placed the provision in the Internal Revenue Code. The ACA requires taxpayers not otherwise exempt to obtain "minimum essential coverage" or pay a penalty. Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(a), (b)(1)). Taxpayers who are not required to file income tax returns for a given year are not subject to this provision. *Id.* § 1501(b) (as amended by Pub. L. No. 111-152, § 1002) (adding 26 U.S.C. § 5000A(e)(2)). In general, the penalty is the greater of a fixed amount or a percentage of the taxpayer's household income, subject to a cap of the national average premium for the lowest-tier plans offered in the new Exchanges for the taxpayer's family size. *Id.* § 1501(b) (adding 26 U.S.C. § 5000A(c)(1), (2)). If the penalty applies, the taxpayer must report it on his income tax return for the taxable year, as an addition to his income tax liability. *Id.* (adding 26 U.S.C. § 5000A(b)(2)). The penalty is assessed and collected in the same manner as other assessable penalties under the Internal

Revenue Code.[16] As the Joint Committee on Taxation noted, the penalty was to be "accounted for as an additional amount of Federal tax owed." *See* JOINT COMM. ON TAXATION, JCX-18-10, TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" 33 n.68 (Mar. 21, 2010).[17] Moreover, during the floor debates, Congressional leaders explicitly defended the provision as an exercise of the taxing power as well as an exercise of the commerce power. *See, e.g.*, 156 Cong. Rec. H1854, H1882 (daily ed. Mar. 21, 2010) (statement of Rep. Miller); 156 Cong. Rec. H1824, H1826 (daily ed. Mar. 21, 2010) (statement of Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (daily ed. Dec. 22, 2009) (statement of Sen. Leahy); 155 Cong. Rec. S13,558, S13,581-82 (daily ed. Dec. 20, 2009) (statement of Sen. Baucus).

That the provision has a regulatory purpose does not place it beyond the General Welfare Clause power.[18] *Sanchez*, 340 U.S. at 44 ("[A] tax does not cease to be valid merely

[16] The Secretary of the Treasury may not collect the penalty through notice of federal tax liens or levies, and may not bring a criminal prosecution for a failure to pay it. Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(g)(2)). Revenues from the minimum coverage penalty are paid into general revenues.

[17] The Joint Committee on Taxation is "a nonpartisan committee of the United States Congress, originally established under the Revenue Act of 1926" that "is closely involved with every aspect of the tax legislative process." *See Overview*, JOINT COMMITTEE ON TAXATION, http://www.jct.gov/about-us/overview.html (last visited Oct. 8, 2010); *see also* 26 U.S.C. §§ 8001-23.

[18] Congress has long used the taxing power as a regulatory tool, in particular, in regulating how health care is paid for in the national market. HIPAA, for example, imposes a tax on any group health plan that fails to comply with limits on exclusions or terminations of applicants with pre-existing conditions. 26 U.S.C. §§ 4980D, 9801-03. In addition, the Internal Revenue Code requires group health plans to offer COBRA continuing coverage to terminated employees, and similarly imposes a tax on any plan that fails to comply. 26 U.S.C. § 4980B.

because it regulates, discourages, or even definitely deters the activities taxed."); *see United States v. Kahriger*, 345 U.S. 22, 27-28 (1953); *cf. Bob Jones Univ.*, 416 U.S. at 741 n.12 (noting that the Court has "abandoned" older "distinctions between regulatory and revenue-raising taxes").[19] So long as a statute is "productive of some revenue," courts will not second-guess Congress's exercise of these powers, and "will not undertake, by collateral inquiry as to the measure of the regulatory effect of a tax, to ascribe to Congress an attempt, under the guise of taxation, to exercise another power denied by the Federal Constitution." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see also United States v. Thompson*, 361 F.3d 918, 922 (6th Cir. 2004) (upholding statute that was not "utterly devoid of a taxing purpose"); *United States v. Birmley*, 529 F.2d 103, 106 (6th Cir. 1976).

The minimum coverage provision easily meets this standard. The Joint Committee on Taxation included the provision in its review of the "Revenue Provisions" of the Act and the Reconciliation Act, analyzing it as a "tax," an "excise tax," and a "penalty." *See* JOINT COMM. ON TAXATION, at 31. Moreover, the Joint Committee, along with the CBO, repeatedly predicted how much revenue the provision would raise and considered that amount in determining the impact of the bill on the deficit. The CBO estimated that the minimum coverage provision would produce about $4 billion in annual revenue. CBO Letter to Rep. Pelosi at tbl. 4 at 2. Thus, the minimum coverage provision produces revenue alongside its regulatory purpose, which is all that Article I, Section 8, Clause 1 requires.

[19] Nor does the statutory label of the provision as a "penalty" matter. "I[n] passing on the constitutionality of a tax law [the Court is] concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (citation and internal quotation omitted).

III. THE MINIMUM COVERAGE PROVISION DOES NOT VIOLATE THE CONSTITUTION'S PROTECTION OF FREE ASSOCIATION

In Count II, plaintiffs allege that the ACA "infringes Plaintiff USCA members' freedom of expressive and intimate association guaranteed by the First and Fifth Amendments." SAC ¶ 42. This Court lacks jurisdiction to reach these claims, as explained above. But, even if the Court were to reach their merits, the ACA threatens neither of the "two distinct" associations protected by the Constitution. *See Roberts*, 468 U.S.at 617–18; *accord Anderson v. City of LaVergne*, 371 F.3d 879, 881 (6th Cir. 2004).

A. The Minimum Coverage Provision Does Not Infringe on Plaintiffs' First Amendment Right of Expressive Association

Plaintiffs' invocation of the First Amendment is unavailing. Plaintiffs claim that the minimum coverage provision compels USCA's individual members "to associate with and finance [qualified health insurance] plans against their will," in violation of their First Amendment right "not to associate," SAC ¶¶ 5, 42, 43. Plaintiffs misunderstand basic First Amendment principles. The First Amendment protects the right to speak, to petition the government, and to worship. *Roberts*, 468 U.S. at 622. The right of expressive association is the "correlative freedom to engage in group effort towards those ends." *Id.*; *see also Rumsfeld v. Forum for Academic & Institutional Rights, Inc.* (*"FAIR"*), 547 U.S. 47, 68 (2006) ("If the government were free to restrict individuals' ability to join together and speak, it could essentially silence views that the First Amendment is intended to protect."). To qualify for this protection, "a group must engage in some form of expression, whether it be public or private." *Boy Scouts of Am. v. Dale*, 530 U.S. 640, 648 (2000). If the group is

engaged in expressive association, a law that "affects in a significant way the group's ability to advocate public or private viewpoints" is subject to strict scrutiny. *Id.*

Contrary to plaintiffs' assertion, the First Amendment protection of association does not contain a blanket "freedom not to associate." The "freedom not to associate" described in *Roberts* refers to a right to avoid a compelled association that "may impair the ability" of a group or an individual to express a message. *Roberts*, 468 U.S. at 623.[20] If that ability to express a message, by the individual or the group, is not impaired by a regulation, the freedom of expressive association is not implicated at all. *See Glickman v. Wileman Bros. & Elliott, Inc.*, 521 U.S. 472, 470-71 (1997) (the Court's "compelled speech case law" is inapplicable where the challenged regulation "does not require respondents to repeat an objectionable message out of their own mouths[,]" "use their own property to convey an antagonistic ideological message[,]" "force them to respond to a hostile message when they 'would prefer to remain silent,'" or "require them to be publicly identified or associated with another's message" (citation and internal quotation omitted)). Here, the minimum coverage provision does not implicate expressive activities. Rather, if it applies to plaintiffs at all, it would simply require them either to secure qualifying insurance coverage by 2014 or to pay a penalty. *See* Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(a), (b)).

Absent any plausible allegation that the statute has impaired plaintiffs' ability to express a message, this "mere association" does not violate the First Amendment. *FAIR*, 547

[20] Plaintiffs rely on *Thomas S. by Brooks v. Flaherty*, 699 F. Supp. 1178 (W.D.N.C. 1988), apparently for the proposition that the freedom "not to associate" is absolute whether or not expressive activity is involved. Their reliance is doubly mistaken. First, *Thomas S.* did not involve a claimed right "not to associate", but instead a claimed right by institutionalized persons to associate with persons outside the institution. Second, *Roberts* and subsequent cases establish that the right protected by the freedom of association is a right to engage (or not) in expressive activities, not a blanket right to avoid economic regulation.

U.S. at 69-70 (rejecting First Amendment "freedom of association" challenge to the Solomon Amendment—which requires law schools to allow military recruiters on campus or lose federal funding—reasoning that "mere association" did not impair law schools' ability "to voice their disapproval of the military's message"). As the foregoing demonstrates, because the ACA does not prohibit plaintiffs from joining together to advance their views on any subject, including the challenged provision, but, at most, simply requires individuals to "associate" with health insurers, plaintiffs have failed to state a valid First Amendment claim. *See id.*; *see also NAACP v. Alabama ex rel. Patterson*, 357 U.S. 449, 460 (1958).

B. The Minimum Coverage Provision Does Not Infringe on Plaintiffs' Constitutionally Protected Intimate Associations

Plaintiffs' claim that the ACA violates the Constitution's protection of intimate association. Their claims are twofold: First, they argue that the Constitution's protection of intimate association is violated when they are forced "to associate with doctors who, and insurers that cover, methods or approaches rejected by Plaintiffs." SAC ¶ 44 [sic]. Second, they assert that the ACA places an undue burden on their intimate association by "depriv[ing] Plaintiffs of the resources they need to associate with private practitioners" who do not accept insurance. *Id.* ¶ 44. Neither claim has merit.

First, the Constitution's protection of intimate association does not extend to the relationships at issue here. Intimate associations are "highly personal relationships" characterized by "relative smallness, a high degree of selectivity in decisions to begin and maintain the affiliation and seclusion from others in critical aspects of the relationship." *Roberts*, 468 U.S. at 618-20. Marriage, childbirth, and co-habitation with one's relatives

qualify as such associations. *Id.* at 617, 619.[21] Plaintiffs' relationships with health insurers, "a large business enterprise[]," are not protected intimate associations; business relationships "seem[] remote from the concerns giving rise to this constitutional protection." *Id.* at 620. Nor does the protection cover plaintiffs' relationships with medical practitioners. *See Nat'l Ass'n for Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043 (9th Cir. 2000). Those relationships are not necessarily characterized by "a high degree of selectivity in decisions to begin and maintain the affiliation," *see Anderson*, 371 F.3d at 881, as doctors generally accept patients for appointments before meeting them and hospitals accept patients who walk through the door. Nor does that relationship presuppose a "deep attachment[] and commitment[]" to the practitioner such that the patient shares "a special community of thoughts, experiences, and beliefs." *Roberts*, 468 U.S. at 619-20.

Second, even if the medical practitioner-patient relationship qualifies as an "intimate human relationship," *id.* at 617, the ACA does not burden it. Plaintiffs cite nothing in the ACA that "compels Plaintiffs to associate with medical providers they wish to avoid." SAC ¶ 44. Plaintiffs may be required to either secure qualifying insurance coverage by 2014 or pay a penalty, but they are not required to obtain medical care, or to obtain such care from practitioners not of their liking. *See* Pub. L. No. 111-148, § 1501(b) (adding 26 U.S.C. § 5000A(a), (b)). Nor does the ACA burden plaintiffs' relationships with medical practitioners who do not accept insurance.[22] They claim that the ACA empties their coffers to such an extent that they will not have the "resources they need" to associate with these

[21] The protection is derived from the Due Process Clause but is "related to" the First Amendment. *See Anderson*, 371 F.3d at 881 (citing *Roberts*, 468 U.S. at 617-18).

[22] In any event, this injury is unripe as plaintiffs cannot know now whether their medical practitioners will be associated with the relevant health insurance plans in 2014.

nonparticipating practitioners. SAC ¶ 44. However, "[h]ere the regulation in question . . . does not impact" the "precise . . . associational right in question." *Angstadt v. Midd-West Sch. Dist.*, 377 F.3d 338, 343-44 (3d Cir. 2004). Under the ACA, plaintiffs can continue to associate with nonparticipating practitioners and the cost for that association is unchanged. Money is fungible; the ACA no more burdens plaintiffs' ability to associate with nonparticipating practitioners than would any regulation that could cost plaintiffs money.[23] If this attenuated impact was the type of burden that could result in an intimate association claim, plaintiffs could also claim that tax increases, failure to raise the minimum wage, or mandatory car insurance injure their marriages. *See Christensen v. Cnty. of Boone, Ill.*, 483 F.3d 454, 463-64 (7th Cir. 2007) (claim fails if "effect on intimate association is incidental").

[23] Even if the ACA did burden this purported intimate association, such a burden is constitutionally permissible. "A 'direct and substantial interference' with intimate associations is subject to strict scrutiny, while lesser interferences are subject to rational basis review." *Anderson*, 371 F.3d at 882. There is no direct and substantial interference here because neither "a large portion of those affected by the rule are absolutely or largely prevented from [forming intimate associations]," nor are "those affected by the rule are absolutely or largely prevented from [forming intimate associations] with a large portion of the otherwise eligible population." *Vaughn v. Lawrenceburg Power Sys.*, 269 F.3d 703, 710 (6th Cir. 2001). Rather, if any burden even exists, it is only "economically burdensome to [associate with] a small number of " practitioners. *Id.* at 712; s*ee also Anderson*, 371 F.3d at 882. As such, rational basis review applies and the ACA easily meets this standard, *see infra* Part IV.A.

IV. THE MINIMUM COVERAGE PROVISION IS CONSISTENT WITH DUE PROCESS

In Counts Three and Four, plaintiffs allege that the minimum coverage provision violates the substantive due process protections of the Fifth Amendment, because it infringes either on their right "not to pay for unwanted [medical] treatment[]," SAC ¶ 48, and on their right not to disclose private medical information to insurers, SAC ¶¶ 53-55. As noted above, plaintiffs lack standing to bring these unripe challenges to the minimum coverage provision. Even if they had standing, the Anti-Injunction Act would bar this attempt to forestall the penalty. On the merits, their due process challenge fails.[24]

A. The Minimum Coverage Provision Does Not Violate a Purported Due Process Right to Forego Insurance

In its modern jurisprudence, the Supreme Court has made clear that a plaintiff must provide "a 'careful description' of the asserted fundamental liberty interest" when raising a substantive due process claim. *Chavez v. Martinez*, 538 U.S. 760, 775-76 (2003); *see also Doe v. Mich. Dep't of State Police*, 490 F.3d 491, 500 (6th Cir. 2007). Plaintiffs' asserted right "not to pay for unwanted [medical] treatment[]," SAC ¶ 48, is not such a careful description, as nothing in the ACA compels plaintiffs to receive unwanted medical treatment. A more precise description of plaintiffs' asserted right is that they prefer not to purchase insurance to cover their health care expenses, and instead to take the chance that their out-of-pocket expenditures, coupled with the health care system's provision of uncompensated care

[24] Plaintiffs seem to allege that the ACA violates their substantive due process rights "not to receive medical treatment or treatment of a particular kind." SAC ¶ 48; *see also id.* ¶¶ 19, 28 ("unwanted medical care"). To the extent plaintiffs raise such a claim, they cite no provision of the ACA that infringes on any of these rights. No such provision exists.

to the uninsured, will suffice to meet their medical needs. That is to say, plaintiffs' claimed right would be one that seeks to maintain the benefits of the ACA—namely, the guarantee that an insurance policy will issue to them when their medical needs so require, with no possibility that a policy will be denied to them for any pre-existing conditions—and to shift the costs of maintaining such a system onto other market participants.

Contrary to plaintiffs' view, there is no fundamental right not to purchase health insurance. The Due Process Clause protects only those fundamental liberty interests that are "objectively, deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (citation and internal quotation omitted). These freedoms include the "rights to marry," "to have children," "to direct the education and upbringing of one's children," "to marital privacy," "to use contraception," "to bodily integrity," "to abortion," and possibly "to refuse unwanted lifesaving medical treatment." *Id.* at 720. The Supreme Court has cautioned against recognizing new fundamental rights, "lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of this Court." *Id.*; *see also Blau v. Fort Thomas Pub. Sch. Dist.*, 401 F.3d 381, 393-94 (6th Cir. 2005).

No ostensible "right" to forgo health insurance and, as a result, to shift one's health care costs to third parties falls into any of these categories. No such right is "deeply rooted in this Nation's history and tradition." No such right is a prerequisite to liberty. *Glucksberg*, 521 U.S. at 720. Indeed, plaintiffs' purported interest in forgoing insurance coverage is purely economic. Plaintiffs' due process claim harks back to the Supreme Court's *Lochner*-era decisions that treated contract rights as absolute, *see Adair v. United States*, 208 U.S. 161

(1908), but the Court has long since repudiated those precedents, *see, e.g.*, *Lincoln Fed. Labor Union v. Nw. Iron & Metal Co.*, 335 U.S. 525, 536 (1949) ("The Court . . . has steadily rejected the due process philosophy enunciated in the *Adair-Coppage* line of cases."); *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379, 392 (1937) ("[F]reedom of contract is a qualified and not an absolute right. . . . Liberty implies the absence of arbitrary restraint, not immunity from reasonable regulations.").

Because any liberty or property interests the ACA may affect are not "fundamental," plaintiffs' due process claim is subject to rational basis review. It is well established that legislative acts "adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Accordingly, the Supreme Court has not invalidated any economic or social welfare legislation on substantive due process grounds since the 1930s. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW 625 (3d ed. 2006).

The ACA as a whole, and the minimum coverage provision in particular, easily meets the rational basis standard. Under this "highly deferential" standard of review, the statute "need only be rationally related" to "any *conceivable* legitimate governmental interest." *Fednav, Ltd. v. Chester*, 547 F.3d 607, 624 (6th Cir. 2008) (internal quotations and citations omitted); *see also Lenscrafters, Inc. v. Robinson*, 403 F.3d 798, 806 (6th Cir. 2005). Congress passed the ACA to address the mounting costs imposed on the economy, the government, and the public as a result of the inability of millions of Americans to obtain affordable health insurance and health care services. Without question, these are legitimate

legislative aims. And, as noted, Congress sensibly found that, without the minimum coverage provision, the Act's insurance market reforms would be counterproductive, Pub. L. No. 111-148, §§ 1501(a)(2)(A), 10106(a), while, with it, the reforms would reduce administrative costs and lower premiums, *id.* §§ 1501(a)(2)(I), (J), 10106(a). Because Congress's objectives were plainly legitimate and its chosen means were rational, under the deferential standard of review applied to substantive due process challenges to economic and social welfare legislation, *Turner Elkhorn*, 428 U.S. at 15, the inquiry ends there.

B. The Minimum Coverage Provision Does Not Violate a Purported Due Process Right of Nondisclosure of Medical Information

Plaintiffs fare no better by recasting their due process theory as one asserting a right not to disclose medical information to insurers. SAC ¶¶ 53-55. Nothing in the ACA requires plaintiffs to disclose such information, or requires insurers to seek disclosure; the ACA in no way weakens the stringent laws protecting medical privacy. Plaintiffs thus do not challenge any governmental action whatsoever, but only the possibility that private insurers will in the future ask them for personal information. But actions by private parties may be attributed to the government, and thereby become subject to a constitutional challenge, only in narrow circumstances. *See Wilcher v. City of Akron*, 498 F.3d 516, 519-21 (6th Cir. 2007) (describing "public function," "compulsion," and "symbiotic relationship" tests for state action). Any hypothetical insurer that asks for personal information from enrollees would not exercise a public function traditionally reserved to the state. *See id.* at 519. Nor would that future insurer act under any governmental compulsion requiring it to seek personal information. *See id.* at 519-20. And there could be no claim of a "symbiotic relationship" in which that insurer is acting as the government's agent in order to gather personal medical

information. *See id.* at 520-21; *see also American Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 57-58 (1999) (challenged decisions of insurers were not state action even though insurers are "extensively regulated"). Any link between the statute and the possibility that insurers will seek medical information is thus far too attenuated for the insurers to be deemed state actors. *See also Citizens for Health v. Leavitt*, 428 F.3d 167, 182 (3d Cir. 2005) (disclosures of medical information for routine uses by private insurers did not constitute state action).[25]

In any event, "the Constitution does not encompass a general right to nondisclosure of private information." *Wilson v. Collins*, 517 F.3d 421, 429 (6th Cir. 2008) (citation and internal quotation omitted). "The Sixth Circuit has narrowly construed the informational-privacy right to apply only to those personal rights that can be deemed fundamental or implicit in the concept of ordered liberty." *Summe v. Kenton Co. Clerk's Office*, 604 F.3d 257, 270 (6th Cir. 2010); *see also Lambert v. Hartman*, 517 F.3d 433, 443 (6th Cir. 2008). Thus far, the court has found that a claimed right to informational privacy rises to a

[25] Plaintiffs can only speculate as to what information insurers would seek from them in the future. This speculation demonstrates that their informational privacy claim is, at a minimum, unripe. The nature of the information that insurers might request in the future is unclear. When § 1201 of the ACA goes into effect, insurers will be prohibited from denying coverage or setting premiums based on pre-existing conditions. Thus, plaintiffs' allegations regarding the practices of private insurers under current law, *see* SAC ¶ 54, provide no basis to believe that future insurers will require detailed medical information from enrollees. Further, the content of enrollment forms for plans in the Exchanges will be subject to regulations to be issued by the Secretary of HHS. Pub. L. No. 111-148, § 1311(c)(1)(F). Neither those regulations nor those forms exist yet. There is no reason to assume that, come 2014, plaintiffs will be unable to find an insurer that does not seek their medical information (let alone blood samples or DNA samples) during the enrollment process. Their claim thus rests upon "contingent future events that may not occur as anticipated, or indeed may not occur at all," and is not ripe. *Thomas*, 473 at 580-81; *see also Wilson v. Collins*, 517 F.3d 421, 430 (6th Cir. 2008) (rejecting due process claim where concerns about possible future disclosure of DNA sample "are purely speculative").

constitutional level "in only two cases: (1) where the release of personal information could lead to bodily harm, and (2) where the information released was of a sexual, personal, and humiliating nature." *Summe*, 604 F.3d at 270 (citing *Bloch v. Ribar*, 156 F.3d 673, 683 (6th Cir. 1998), and *Kallstrom v. City of Columbus*, 136 F.3d 1055 (6th Cir. 1988)). If plaintiffs could show that a specific disclosure of particular private information fell into one of these categories and thus infringed upon a fundamental right, the Court would then need to balance the governmental interest in the disclosure with the individual's interest in keeping information private. *See Lambert*, 517 F.3d at 440.

Plaintiffs do not allege any interest in privacy akin the interests at issue in *Kallstrom* or *Bloch*. There can be no plausible assertion that the completion of an insurer's enrollment form would subject the plaintiffs to bodily harm, or that insurers' enrollment forms would cause plaintiffs to be humiliated by the public disclosure of personal, sexual information. Indeed, there is no realistic threat of public disclosure of any information at all, because another federal statute, HIPAA, strictly limits the manner in which private insurers may use individuals' medical information. 42 U.S.C. § 1320d, *et seq.*; *see also* 45 C.F.R. § 164.502. Absent any real threat of public disclosure, plaintiffs can identify no actual, impending, or potential violation of the Due Process Clause. *See Whalen v. Roe*, 429 U.S. 589, 600-02 (1977) (rejecting due process claim where statute required creation of a database, but information in that database was not made publicly available).

CONCLUSION

For the foregoing reasons, defendants' motion to dismiss should be granted and this case should be dismissed in its entirety.

Dated: October 8, 2010

Respectfully submitted,

TONY WEST
Assistant Attorney General

IAN HEATH GERSHENGORN
Deputy Assistant Attorney General

STEVEN M. DETTELBACH
United States Attorney

JENNIFER RICKETTS RIVERA
Director

SHEILA LEIBER
Deputy Director

LYNNE H. BUCK
KATHLEEN MIDIAN
Assistant United States Attorneys

/s/ Karen P. Seifert
JOEL McELVAIN (D.C. Bar #448431)
TAMRA T. MOORE (D.C. Bar #488392)
KAREN P. SEIFERT (N.Y. Bar)
Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, N.W.
Washington, D.C. 20001
Ph: (202) 305-0891
Fax: (202) 616-8202
karen.p.seifert@usdoj.gov

Counsel for Defendants

CERTIFICATION

This case has been assigned to the standard track. However, the page limitations applicable to this memorandum have been modified by order of Judge Dowd. This memorandum is less than 50 pages in length and complies with that modification.

Dated: October 8, 2010

Respectfully submitted,

/s/ Karen P. Seifert

KAREN P. SEIFERT (N.Y. Bar)
Attorney
United States Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, N.W.
Washington, D.C. 20001
Ph: (202) 305-0891
Fax: (202) 616-8202
karen.p.seifert@usdoj.gov

Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on October 8, 2010, a copy of foregoing Memorandum in Support of Defendants' Motion to Dismiss Plaintiffs' Second Amended Complaint was filed electronically. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt. All other parties will be served by regular U.S. mail. Parties may access this filing through the Court's system.

Dated: October 8, 2010

Respectfully submitted,

/s/ Karen P. Seifert

KAREN P. SEIFERT (N.Y. Bar)
Attorney
United States Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue, N.W.
Washington, D.C. 20001
Ph: (202) 305-0891
Fax: (202) 616-8202
karen.p.seifert@usdoj.gov

Counsel for Defendants