No. 10-2388

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

THOMAS MORE LAW CENTER, ET AL.,
Plaintiffs-Appellants,

v.

BARACK HUSSEIN OBAMA, ET AL.,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN

BRIEF FOR APPELLEES

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

This case presents a constitutional challenge to the minimum coverage provision of the Patient Protection and Affordable Care Act, which requires non-exempted individuals to maintain a minimum level of health insurance coverage or pay a tax penalty. This provision regulates economic activity that has substantial adverse effects on the interstate health care market. People without insurance consume health care services but, as a class, fail to pay the cost of the services that they obtain. The minimum coverage provision is designed to help curb the cost of such uncompensated care, which reached $43 billion in 2008. The provision is also essential to the viability of the Affordable Care Act's new insurance regulations that protect individuals from industry practices that have prevented them from obtaining and keeping health insurance.

The district court rejected plaintiffs' constitutional challenge and upheld the minimum coverage provision as a valid exercise of Congress's Commerce Clause power. Given the importance of the matter presented, the federal government respectfully requests oral argument.

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JURISDICTIONAL STATEMENT

The district court's jurisdiction arose under 28 U.S.C. §§ 1331 and 1346. The court entered final judgment on October 21, 2010. Plaintiffs filed a notice of appeal on October 22, 2010. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly held that the minimum coverage provision of the Patient Protection and Affordable Care Act ("Affordable Care Act"), 26 U.S.C.A. § 5000A, is a valid exercise of Congress's commerce power.

2. Whether the minimum coverage provision is also independently authorized by Congress's taxing power.

STATEMENT OF THE CASE

Four individual plaintiffs and the Thomas More Law Center, a public interest law firm, challenge the constitutionality of the minimum coverage provision of the Affordable Care Act, which requires non-exempted individuals to maintain a minimum level of health insurance coverage or pay a tax penalty.

The minimum coverage provision regulates economic activity that has substantial adverse effects on the interstate health care market. People without insurance consume health care services but, as a class, fail to pay the cost of the services that they obtain. The minimum coverage provision is designed to help curb the cost of such uncompensated care, which imposed a $43 billion burden on

the national health care market in 2008. The provision is instrumental to the Affordable Care Act's new insurance regulations that protect individuals from industry practices that have prevented them from obtaining and keeping health insurance. These new statutory provisions bar insurance companies from denying coverage to persons with a pre-existing medical condition (a requirement known as "guaranteed issue") and from charging higher premiums on the basis of a person's medical history (a requirement known as "community rating"). Congress concluded, in light of expert testimony and the experience of state regulators, that a system of guaranteed issue and community rating is not viable if consumers of health care services can postpone the purchase of insurance until they are faced with substantial imminent medical costs.

The individual plaintiffs do not have health insurance. They acknowledge that they have received and will need health care, but declare that they have made the economic calculation to "pay for health care expenses as [they] need them." R-7, Exhibit 4, ¶ 3 (DeMars Decl.); R-7, Exhibit 5, ¶ 3 (Hyder Decl.). Plaintiffs contend that requiring them to maintain a minimum level of insurance coverage imposes "unprecedented governmental mandates that restrict their personal and economic freedoms." Pl. Br. 4. Plaintiffs do not, however, assert a due process

claim for purported deprivation of their individual liberties, but instead allege that the minimum coverage provision is not a proper regulation of interstate commerce.

The district court rejected this claim and upheld the minimum coverage provision as a valid exercise of Congress's Commerce Clause power. R-28 (10/7/10 Order). The court explained that "[t]he crux of plaintiffs' argument is that the federal government has never attempted to regulate inactivity, or a person's mere existence within our Nation's boundaries, under the auspices of the Commerce Clause," and "that if the Act is found constitutional, the Commerce Clause would provide Congress with the authority to regulate every aspect of our lives, including our choice to refrain from acting." *Id*. at 11. The court rejected the premise of that argument, explaining that the "decision whether to purchase insurance or to attempt to pay for health care out of pocket, is plainly economic." *Id*. at 16. The court explained that these decisions, "viewed in the aggregate, have clear and direct impacts on health care providers, taxpayers, and the insured population who ultimately pay for the care provided to those who go without insurance." *Ibid*.

The court emphasized that "[t]he health care market is unlike other markets." *Ibid*. "No one can guarantee his or her health, or ensure that he or she will never participate in the health care market." *Ibid.* Thus, "[t]he question is how

participants in the health care market pay for medical expenses — through insurance, or through an attempt to pay out of pocket with a backstop of uncompensated care funded by third parties." *Ibid.* "Far from 'inactivity,' by choosing to forgo insurance plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now through the purchase of insurance." *Ibid.* "[P]laintiffs in this case are participants in the health care services market," and they "have made a choice regarding the method of payment for the services they expect to receive." *Id*. at 17. "How participants in the health care services market pay for such services has a documented impact on interstate commerce," and "this market reality forms the rational basis for Congressional action designed to reduce the number of uninsureds." *Ibid*.

The court further explained that the minimum coverage provision is valid Commerce Clause legislation because it forms a key part of the Affordable Care Act's overall scheme to create a market in which all persons are guaranteed insurance coverage without regard to pre-existing medical conditions. *Id*. at 18. The court observed that "[t]his is not a market created by Congress, it is one created by the fundamental need for health care and the necessity of paying for such services received." *Ibid*. "In 2014, the Act will bar insurers from refusing to cover individuals with pre-existing conditions and from setting eligibility rules

based on health status or claims experience." *Ibid*. "The uninsured, like plaintiffs, benefit from the 'guaranteed issue' provision in the Act, which enables them to become insured even when they are already sick." *Ibid*. "Without the minimum coverage provision, there would be an incentive for some individuals to wait to purchase health insurance until they needed care, knowing that insurance would be available at all times." *Ibid*. "As a result, the most costly individuals would be in the insurance system and the least costly would be outside it." *Ibid*. "In turn, this would aggravate current problems with cost-shifting and lead to even higher premiums." *Ibid*. The court explained that this "prospect of driving the insurance market into extinction led Congress to find that the minimum coverage provision was essential to the larger regulatory scheme." *Ibid.*

Having upheld the minimum coverage provision under Congress's commerce power, the court had no need to decide whether the provision also may be upheld as an exercise of Congress's taxing power. The court held that a penalty imposed in aid of valid Commerce Clause legislation is not subject to the Constitution's constraints on taxes, *id*. at 19 — a ruling that plaintiffs do not challenge on appeal.[1]

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[1] The government does not challenge the district court's threshold determinations that individual plaintiffs have standing, that the suit is ripe, and that the suit is not barred by the Anti-Injunction Act. R-28 at 7-11.

The district court denied plaintiffs' motion for a preliminary injunction and entered judgment for the government on the claims at issue here. *Id*. at 20. The parties stipulated to dismissal without prejudice of other claims that were included in the complaint but not considered by the court. R-29.

STATEMENT OF FACTS

In the Affordable Care Act, Congress made detailed findings addressed to the standards that have been established by the Supreme Court for assessing whether Congress has acted within its Commerce Clause power. Specifically, Congress found that the Act's minimum coverage requirement regulates "economic and financial decisions about how and when health care is paid for," 42 U.S.C.A. § 18091(a)(2)(A); that the consumption of health care without insurance has substantial adverse effects on the interstate health care market, *id*. § 18091(a)(2)(F); and that the minimum coverage requirement is "essential" to the Act's broader insurance reforms, *id*. § 18091(a)(2)(I).

The Affordable Care Act seeks to ameliorate the longstanding crisis in the interstate market for health care services in the United States, which accounts for more than 17% of the nation's gross domestic product. Ever-increasing numbers of people without health insurance have consumed ever-increasing amounts of medical services for which they do not pay. These uncompensated costs impose

significant economic consequences on other participants in the health care market throughout the country. They result in higher premiums which, in turn, make insurance unaffordable to even greater numbers of people. At the same time, insurance companies deny coverage to millions of individuals across the nation who have pre-existing medical conditions.

Congress addressed these national problems by enacting the Affordable Care Act. The Act builds upon and adds to existing federal programs and regulations to effect a comprehensive reform of our national health care system. Recognizing that the interstate health care market is unlike any other economic market and that the ills in our health care system cannot as a practical matter be cured state-by-state, Congress adopted a wide-ranging set of national solutions in the Affordable Care Act that include the minimum coverage provision at issue here.

I. Background

A. The interstate market for health care services is unique.

In responding to the health care crisis and seeking to regulate the interstate market for health care services, Congress confronted a market that is different in critical respects from any other market. Spending in the health care market is extraordinary, accounting for 17.6% of the nation's gross domestic product in 2009. Centers for Medicare & Medicaid Services ("CMS"), National Health

Expenditure 2009 Highlights, at 1 (2011). Participation is essentially universal; the timing and magnitude of an individual's need for expensive medical care are unpredictable; and, across the nation, emergency care is routinely provided without regard to an individual's ability to pay. The market is also unique in that individuals typically pay for health care services through private or government insurance.

Total spending on health care services in the United States reached $2.5 trillion in 2009. *Ibid.* More than 80% of adults nationwide visited a doctor or other health care professional one or more times in 2009. Centers for Disease Control and Prevention ("CDC"), National Center for Health Statistics, Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009, table 35 (2010). About one in five Americans visits the emergency room at least once a year. CDC, National Center for Health Statistics, Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?, at 2 (2010); CDC, National Center for Health Statistics, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2009, table 16 (2010).

Although most people obtain health care services on an ongoing basis, they cannot accurately predict their future need for such services. "Most medical expenses for people under 65" result "from the bolt-from-the-blue event of an

accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." Statement of Professor Mark V. Pauly, Senate/House Joint Economic Committee (Sept. 22, 2004), 2004 WL 2107555. Costs mount rapidly for the treatment of even the most common significant health problems. For example, the average cost of an appendectomy in 2010 was $13,123. International Federation of Health Plans, 2010 Comparative Price Report: Medical and Hospital Fees By Country, at 14. The average cost of a day in the hospital was $3,612, *id.* at 9; of a hospital stay, $14,427, *id.* at 10. The average cost of a Caesarian-section was $13,016, *id.* at 12; of bypass surgery, $59,770, *id.* at 16; and of an angioplasty, $29,055, *id.* at 17. An MRI alone cost $1,009 on average, *id.* at 8; an abdominal CT scan, $536, *id.* at 5. Drug treatment for a common form of cancer costs more than $150,000 a year. Meropol et al., *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007). Thus, although the potential for financially ruinous burdens is plain, what actually will happen — the "frequency, timing, and magnitude" of an individual's demand for health care — is unknowable. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007).

Another sharp distinction between the interstate health care market and other markets is that individuals receive, and expect to receive, many costly health care

services without regard to their ability to pay. Even before the enactment of the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") in 1986, many state legislatures and courts had recognized that hospitals cannot properly turn away people in need of emergency treatment. *See, e.g.*, *Mercy Medical Center of Oshkosh, Inc. v. Winnebago County.*, 206 N.W.2d 198, 201 (Wis. 1973) ("It would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that person could not at that moment assure payment for the service."). For twenty-five years, EMTALA has incorporated this principle in federal law by requiring hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, regardless of whether the person has insurance or otherwise can pay. 42 U.S.C. § 1395dd; *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (per curiam).

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

Reflecting the special characteristics of the national health care services market, payment for health care services is usually made through insurance. In 2009, when national health care spending totaled about $2.5 trillion, payments by private health insurers constituted 32% of national health care spending. CMS,

2009 National Health Expenditure Data, table 3 (2011). Employment-based insurance plans accounted for most privately issued coverage; about 59% of the non-elderly U.S. population (156.2 million people) had employer-based health insurance in 2009. Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 448 (2011). In that year, about 5.2% of the non-elderly population (13.8 million people) had health insurance purchased directly from insurance companies in the individual market. *Ibid.*

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

payments for uncovered services — accounted for only 12% of national health care spending in 2009. *Id*., table 3.

As these figures indicate, the federal government's involvement in the system of health care financing is pervasive. For 2009, federal spending on Medicare and Medicaid came to around $750 billion, and billions more were spent on additional programs such as programs for veterans. Congressional Budget Office ("CBO"), The Long-Term Budget Outlook, at 30 (2010). Moreover, those figures do not include the federal government's longstanding use of tax incentives to finance health care costs. Employees who receive employment-based health coverage do not pay federal tax on the value of employer contributions, 26 U.S.C. §§ 105(b), 106, and employers that provide such coverage for their employees may deduct its cost. *Id*. § 162(a)(1). Thus, money paid by employers for employees' health insurance is not subject to federal corporate income taxes or individual income and payroll taxes. CBO, Key Issues In Analyzing Major Health Proposals, at 30 (2008) ("Key Issues"). Experts estimated that federal tax subsidies for employer-sponsored insurance would exceed $240 billion in 2010. Burman et al., *Tax Subsidies for Private Health Insurance*, Robert Wood Johnson Foundation (2009).

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

An estimated 18.8% of the non-elderly United States population (about 50 million people) had no form of health insurance for 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8. Notwithstanding their status with regard to the insurance market, people without insurance are active participants in the interstate health care market and, nationwide, they consume over $100 billion of health care services annually. Families USA, Hidden Health Tax: Americans Pay a Premium, at 2 (2009) ($116 billion in 2008); *see also*, *e.g.*, CDC, National Center for Health Statistics, Health, United States, 2009, at 318, table 80 (2010) (in 2007, 80% of those without insurance at some point during a 12-month period had at least one visit to a doctor or emergency room).

Although they consume billions of dollars in medical services, people without insurance, as a group, cannot pay the cost of the services they receive. Because, as discussed above, hospitals are generally required to provide many costly services without regard to a patient's ability to pay, the uninsured "receive treatments from traditional providers for which they either do not pay or pay very little." CBO, Key Issues at 13. Congress found that in 2008, the cost of providing

uncompensated health care to the uninsured — *i.e.*, care not paid for by the patient or a third party — was $43 billion. 42 U.S.C.A. § 18091(a)(2)(F); *see also* Families USA, Hidden Health Tax at 2, 6. Congress further found that health care providers pass on a significant portion of these costs "to private insurers, which pass on the cost to families," increasing premiums paid by families who carry insurance by an average of "over $1,000 a year." 42 U.S.C.A. § 18091(a)(2)(F); *see also* Families USA, Hidden Health Tax at 2, 6.

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

In 2009, the percentage of the non-elderly population with private health insurance coverage (64.2%) was lower than the percentage in 2000 (73.4%). Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). The percentage covered by employment-based plans, traditionally the largest source of private health insurance, declined from 68.3% in 2000 to 59% in 2009. *Ibid*.

People who attempt to purchase health insurance in the individual insurance market face significant obstacles. Insurers scrutinize the medical condition and history of each applicant to determine their eligibility and premiums in a process known as "medical underwriting." CBO, Key Issues at 8, 80. Conditions as

common as asthma, ear infections, and high blood pressure can create problems in obtaining coverage. 47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance, 110th Cong. 52 (2008) (Prof. Hall, Wake Forest Univ.). A recent national survey estimated that 12.6 million non-elderly adults — 36% of those who tried to purchase health insurance in the previous three years from an insurance company in the individual insurance market — were denied coverage, charged a higher rate, or offered limited coverage because of a pre-existing condition. Department of Health and Human Services, Coverage Denied: How the Current Health Insurance System Leaves Millions Behind (2009). More than 57 million non-elderly Americans have some pre-existing medical condition, and thus, absent the Affordable Care Act, would be at risk for a denial of insurance coverage in the individual market. Families USA, Health Reform: Help for Americans with Pre-Existing Conditions, at 2 (2010).

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

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

II. The Affordable Care Act

Congress addressed the crisis in the national health care system through the Affordable Care Act. Through a series of measures, the Act will make affordable health care coverage widely available, protect consumers from restrictive insurance industry underwriting practices, and reduce the cost-shifting in the interstate health care market that increases the premiums of insured consumers.

First, the Act builds upon the existing nationwide system of employer-based health insurance that is the principal private mechanism for health care financing. 42 U.S.C.A. § 18091(a)(2)(D). As with previous measures designed to encourage employer-based insurance, Congress used the federal tax laws to help achieve its goal, establishing tax incentives for small businesses to purchase health insurance for their employees, 26 U.S.C.A. § 45R, and prescribing tax penalties under specified circumstances for certain large businesses that do not offer their full-time employees adequate coverage. *Id*. § 4980H.

Second, the Act creates insurance exchanges to allow individuals, families, and small businesses to use the leverage of collective buying power to obtain prices and benefits that are competitive with large-employer group plans. 42 U.S.C.A. § 18031.

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

Fourth, the Act imposes new regulations on insurance companies to protect individuals from industry practices that have prevented people from obtaining and keeping health insurance. The Act bars insurance companies from refusing to cover individuals with a pre-existing medical condition, 42 U.S.C.A. §§ 300gg-1(a), 300gg-3(a), canceling insurance absent reasons such as fraud or intentional misrepresentation of material fact, *id.* § 300gg-12, charging higher premiums based on a person's medical history, *id.* § 300gg, and placing lifetime dollar caps on the benefits of the policyholder for which the insurer will pay, *id.* § 300gg-11.

Fifth, through the minimum coverage provision at issue here, the Act requires that non-exempted individuals maintain a minimum level of health insurance or pay a tax penalty. 26 U.S.C.A. § 5000A.[2] The penalty does not apply to individuals who do not have sufficient household income to be required to file a federal tax return, who cannot obtain minimum essential coverage costing 8% or less of their household income, or who establish that obtaining coverage would constitute a financial hardship. *Id.* § 5000A(e).

Congress exempted from the minimum coverage requirement members of "health care sharing ministries" who do not participate in the general health care market. *Id.* § 5000A(d)(2)(B). Similarly, Congress provided an exemption for individuals who adhere to established tenets or teachings of religious sects that are "conscientiously opposed to acceptance of the benefits of any private or public insurance," if the sect makes "provision for their dependent members" and meets other requirements. *Id.* § 5000A(d)(2)(A) (incorporating the definition of "religious sect" in § 1402(g)(1) of the Internal Revenue Code).

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

Many of the Act's provisions, including the minimum coverage requirement and most of the prohibitions on medical underwriting, take effect in 2014. The CBO projected that the Act's various provisions, taken in combination, will reduce the number of non-elderly people without insurance by about 32 million by 2019. Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives, at 9 (Mar. 20, 2010).

SUMMARY OF ARGUMENT

The Affordable Care Act as a whole, and the minimum coverage provision in particular, regulate the diverse economic means by which consumers pay for health care services in the $2.5 trillion interstate health care market. The Act reflects the considered effort of the elected branches of government — based on weeks of hearings, months of debate, and detailed empirical studies — to stem a crisis in the health care market that threatens the long-term vitality of the U.S. economy.

I. A. The requirement that health care consumers have insurance to pay for the health care services they consume is a quintessential exercise of Congress's power to regulate interstate commerce. The regulation furthers two principal economic goals. First, it prevents the substantial cost-shifting in the interstate health care market that results from the practice of consuming health care without

insurance. Second, the minimum coverage requirement is key to the viability of the Act's requirement that insurers provide coverage to all persons without regard to their medical condition or history and without charging more based on that condition or history.

Fundamental features of the legislation and the interstate health care services market are not questioned. It is not disputed that virtually all Americans, including the individual plaintiffs, participate in the health care services market, and that the requirement to maintain minimum coverage regulates the payment for services in that market. Nor is it controverted that the need for health care services is unpredictable and that people who endeavor to pay for such services without insurance cannot, as a class, pay for the services they obtain. In 2008, the cost of such uncompensated health care services reached $43 billion.

The federal government, along with state and local governments, shoulders some of these costs. Health care providers pass much of the remainder on to private insurers, which pass them on to their customers. Rising premiums contribute in turn to the decline in the percentage of the population that is covered by private insurance. Completing the cycle, the growing percentage of people without health insurance further inflates the costs of insurance premiums for other consumers. The Affordable Care Act seeks to break this cycle by requiring

consumers to maintain minimum levels of insurance coverage to meet health care costs.

The Act also seeks to break this cycle by restricting the medical underwriting practices that have precluded many Americans from obtaining insurance because of pre-existing medical conditions, and that have made insurance unaffordable for many others. The statute thus makes persons such as the individual plaintiffs legally insurable regardless of past, present, or future illness or injury, and ensures that they will not be charged higher premiums based on medical condition or history. The experience of state insurance regulators demonstrates that such a system of guaranteed coverage and community rating is unworkable if health care consumers can postpone the purchase of insurance until their medical costs outstrip their insurance premiums.

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

B. Plaintiffs' argument reduces to the contention that the minimum coverage requirement is not a necessary and proper means of achieving wholly

permissible regulatory ends. Their "inactivity" argument misconceives the nature of the regulatory scheme and the governing Commerce Clause principles.

1. The Supreme Court has long held that great deference must be accorded to the regulatory means that Congress selects to accomplish its legitimate regulatory objectives. That deference reflects both a proper allocation of authority to the democratically-elected branches of government, and a recognition of greater capacity of those branches to make such operational choices. Thus, Justice Scalia observed in his concurring opinion in *Raich* that "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" 545 U.S. at 36 (quoting *United States v. Wrightwood Dairy Co*., 315 U.S. 110, 118-19 (1942)). "[T]he relevant inquiry is simply 'whether the means chosen are "reasonably adapted" to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *United States v. Comstock*, 130 S. Ct. 1949, 1957 (2010) (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment)).

The means that Congress adopted to achieve the Affordable Care Act's legitimate goals are entirely proper and are adapted to the unique conditions of the national market for health care services. Participation in the market is nearly

universal, and, in contrast to other markets with widespread participation, consumers cannot predict the timing and the extent of their need for health care services. When that need arises, people depend on an expensive medical infrastructure to provide services whose costs can easily dwarf a consumer's other expenses and exceed the consumer's ability to pay. The usual means of payment for services in the health care market is thus by insurance, which is crucial to the ability of most individuals to pay for the health care services they obtain.

Unlike in other markets, consumers receive very expensive forms of medical treatment without regard to their ability to pay. Health insurance is the most effective means to restrict the extent to which individuals shift their health care costs onto other market participants. Congress had far more than a rational basis to conclude that the consumption of health care services without insurance has a substantial effect on interstate commerce and that such consumption, "if left unregulated in the aggregate, could work to undermine Congress's ability to regulate the larger interstate commercial activity." *United States v. Bowers*, 594 F.3d 522, 529 (6th Cir. 2010).

2. The district court found, and plaintiffs admit, that they participate in the market for health care services. Plaintiffs are "inactive" only in the sense that they "do not intend to engage in the commercial activity of purchasing health

insurance." Pl. Br. 14. But insurance requirements are not imposed because an individual or corporation has entered the insurance market. They are imposed because of costs and risks incurred in a broader market — here, the market for health care services. Plaintiffs' attempt to divorce their participation in the health care market from their means of paying for services in that market disregards the teachings of the Supreme Court, which has rejected such artificial distinctions in favor of "broad principles of economic practicality." *United States v. Lopez*, 514 U.S. 549, 571 (1995) (Kennedy, J., concurring).

Although plaintiffs insist that application of the insurance requirement must await an "affirmative" transaction on their part, the requirement by its nature must apply before an individual appears at the emergency room. In the case of automobile insurance, the government can appropriately make procurement of insurance a condition of access to the highways. It cannot, however, properly condition access to the emergency room on production of a health insurance certificate, as plaintiffs do not dispute.

3. At bottom, plaintiffs' rhetoric concerns not the limits of the Commerce Clause, but the scope of governmental authority generally. The decisions they invoke were concerned with preserving "a distinction between what is truly national and what is truly local." *United States v. Morrison*, 529 U.S. 598, 608

(2000) (quoting *Lopez*, 514 U.S. at 567-568). Plaintiffs do not suggest that regulation of the $2.5 trillion interstate health care market, which has long been subject to federal regulation, intrudes into a domain reserved exclusively to the states. Their real quarrel is not with the distinction between federal and state authority, but with *any* requirements to purchase health insurance, which they decry as "unprecedented governmental mandates that restrict their personal and economic freedoms." Pl. Br. 4.

Such assertions might have been relevant to the type of substantive due process claim entertained in the *Lochner* era, but they have no bearing on the scope of Congress's commerce power. The minimum coverage provision restricts "freedom" only insofar as it curtails economic options to attempt, as plaintiffs put it in their declarations, "to pay for health care expenses as [they] need them," and pass unaffordable costs onto other market participants. The regulation is well within Congress's commerce power and cannot credibly be said to "effectively reverse[] the American Revolution[.]" Pl. Br. 13.

II. The district court, having upheld the minimum coverage provision under the commerce power, had no need to consider whether it also may be upheld under the taxing power. The court correctly held that a penalty imposed in aid of valid

Commerce Clause legislation is not subject to the Constitution's constraints on the taxing power — a ruling that plaintiffs do not challenge.

If the Court reaches the question, however, the minimum coverage provision is also a valid exercise of the taxing power. In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co*., 312 U.S. 359, 363 (1941).

The minimum coverage provision is in the Tax Code and it operates as a tax. The provision is projected to raise billions of dollars in revenue each year once it is fully in effect. The penalty for failure to maintain minimum coverage is calculated with reference to household income, and it is payable to the Internal Revenue Service in the same fashion as other federal income taxes and assessable penalties. The variability in the application and amount of the assessment refutes any claim that it is a capitation tax. Accordingly, during the legislative debates, proponents of the minimum coverage provision properly defended the measure as a valid exercise of Congress's taxing power.

ARGUMENT

I. Standard of Review

This Court reviews *de novo* a challenge to the constitutionality of a statute. *Bowers*, 594 F.3d at 527.

II. The Minimum Coverage Provision Is a Valid Exercise of Congress's Commerce Power.

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

The Constitution grants Congress power to "regulate Commerce . . . among the several States," U.S. Const., art. I, § 8, cl. 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id*. cl. 18. This grant of authority allows Congress to regulate not only interstate commerce but also to address other conduct that "substantially affect[s] interstate commerce." *Raich*, 545 U.S. at 16-17. In assessing those substantial effects, Congress's focus is necessarily broad-gauged. Congress may consider the aggregate effect of a particular form of conduct by those subject to regulation, and need not predict case by case whether and to what extent particular individuals in the class will contribute to those aggregate effects. *Id.* at 22; *Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942).

In reviewing the validity of legislation enacted under the commerce power, a court's task "is a modest one." *Raich*, 545 U.S. at 22. The court "need not determine" whether the regulated activities, "taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Ibid*. This deferential standard reflects both separation of powers principles and Congress's superior capacity to make empirical judgments and operational choices. Courts owe "Congress' findings deference in part because the institution is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon legislative questions." *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180, 195 (1997) (internal quotation marks omitted). "This principle has special significance in cases, like this one, involving congressional judgments concerning regulatory schemes of inherent complexity[.]" *Id*. at 196. "This is not the sum of the matter, however." *Ibid*. Courts "owe Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power," lest a court "infringe on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Ibid*. Accordingly, a court "may only invalidate a congressional enactment passed pursuant to the Commerce Clause if it bears no rational relation

to interstate commerce." *Norton v. Ashcroft*, 298 F.3d 547, 555 (6th Cir. 2002) (quoting *United States v. Faasse*, 265 F.3d 475, 481 (6th Cir. 2001) (en banc)).

Congress's findings and the legislative record leave no doubt that the minimum coverage provision regulates economic conduct that has enormous impact on interstate commerce. First, by regulating the means of payment in the market for health care services, the statute addresses consumption of health care services without payment, a problem that costs tens of billions of dollars annually and that imposes those costs on the great majority of people who purchase such services using insurance. Second, the provision is instrumental to the viability of the statute's ban on medical underwriting, which guarantees persons such as plaintiffs that they will be insurable regardless of illnesses or accidents.

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

The interstate nature of the massive market for health care services is not in dispute. Nor is it controverted that Americans, including the individual plaintiffs, participate in the market for health care services whether or not they have health insurance. *See*, *e.g.*, CDC, National Center for Health Statistics, Health, United States, 2009, at 318 table 80 (2010) (80% of those without insurance at some point during a 12-month period had at least one visit to a doctor or emergency room);

CDC, National Center for Health Statistics, Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?, at 2 (2010) (20% of uninsured adults aged 18-44 visited the emergency room at least once in 2007); CDC, National Center for Health Statistics, Summary Health Statistics for U.S. Children: National Health Interview Survey, 2009, table 16 (2010) (18% of uninsured children visited the emergency room at least once in 2009).

As the district court explained, decisions about how to pay for health care services — including "whether to purchase insurance or to attempt to pay for health care out of pocket" — are "plainly economic." R-28 at 16. And because people without insurance, as a class, do not pay for all the health care services that they consume, these economic decisions "have clear and direct impacts on health care providers, taxpayers, and the insured population who ultimately pay for the care provided to those who go without insurance." *Ibid*.

"In general, individuals who fail to purchase health insurance have a diminished capacity to purchase health care services, and increase overall health care costs." 156 Cong. Rec. E506-01, 2010 WL 1133757 (Rep. Waxman) (Mar. 25, 2010). Indeed, a 2005 study found that on average, uninsured people in households at or above the median income pay for less than half the cost of the medical care that they consume. Herring, *The Effect of the Availability of Charity*

Care to the Uninsured on the Demand for Private Health Insurance, 24 J. Health Econ. 225, 229-30 (2005). Moreover, they pay a diminishing percentage of their costs as their consumption of medical services increases. *Ibid.*[3]

Congress made statutory findings that quantified this impact on interstate commerce — $43 billion in the aggregate cost of providing uncompensated care to the uninsured in 2008. 42 U.S.C.A. § 18091(a)(2)(F). Congress also made findings regarding how these costs affect the interstate health care market — costs are passed on from providers "to private insurers, which pass on the cost to families." *Ibid.* Congress determined that this cost shifting inflates the premiums that families must pay for their health insurance "by an average of over $1,000 a year." *Ibid.*; *see also* 156 Cong. Rec. E506-01, 2010 WL 1133757 (Rep. Waxman) (Mar. 25, 2010) ("[m]edical providers try to recoup the cost from private insurers," which in turn raise premiums); Families USA, Hidden Health Tax at 2, 6. In California, for example, an estimated ten percent of the cost of health insurance premiums is attributable to uncompensated care consumed by people without insurance. S. Rep. No. 111-89 at 2 (2009).

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[3] In households at or above the median income, uninsured individuals who consumed between $250 and $2,500 in medical services paid 77.6% of their costs. That percentage declined to 59.3% for people consuming between $2,500 and $10,000, and dropped to 22.1% for people consuming over $10,000. Herring, *supra*, at 230.

The congressional findings and legislative record amply support Congress's authority, in regulating the national health care market, to preclude the often unsuccessful practice of attempting to pay for health care without insurance, by imposing a minimum coverage requirement. The Supreme Court's precedents make clear that it is irrelevant whether a particular individual's consumption of health care without insurance will impose a substantial burden on the interstate health care market, because it is the aggregate impact that provides the basis for the exercise of the commerce power. Thus, in the Supreme Court's decisions in *Wickard* and *Raich*, it did not matter that the individuals' consumption of home-grown wheat and home-grown marijuana, respectively, would have had only a "trivial" impact on the interstate markets for those commodities. *Raich*, 545 U.S. at 18 (quoting *Wickard*, 317 U.S. at 127). The important point was that such consumption, "when viewed in the aggregate," would have had a substantial impact on the interstate markets. *Id*. at 19 (citing *Wickard*).

Nor does it matter than not every uninsured person will shift health care costs in any given year. Millions will do so, and the cumulative impact of such cost-shifting is to impose a multi-billion dollar annual burden on interstate commerce — a burden that easily qualifies as "substantial." Plaintiffs do not deny that the practice of obtaining health care without insurance, "viewed in the

aggregate," has "clear and direct impacts on health care providers, taxpayers, and the insured population who ultimately pay for the care provided to those who go without insurance." R-28 at 16 (10/7/10 Order). Congress is not required "to legislate with scientific exactitude," *Raich*, 545 U.S. at 17, and does not have to predict, person-by-person, who among the uninsured will receive medical services and fail to pay in a given year. The Supreme Court has repeatedly held that where "Congress decides that the 'total incidence' of a practice" — here, the practice of consuming health care without insurance — "poses a threat to a national market, it may regulate the entire class." *Ibid*. (quoting *Perez v. United States*, 402 U.S. 146, 154-155 (1971)).

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

As demonstrated above, the minimum coverage provision is valid Commerce Clause legislation because it regulates the means of payment for health care services to prevent substantial cost-shifting to other participants in the health care market. It is also valid Commerce Clause legislation because it "operates as an essential part of a comprehensive regulatory scheme" to make affordable health care coverage widely available. R-28 at 18 (10/7/10 Order). Learning from the experience of state regulators, Congress recognized that requirements that insurers offer coverage and set premiums without regard to pre-existing medical conditions

are infeasible if participants in the market for health care services can postpone the purchase of insurance until an acute medical need arises. Accordingly, Congress concluded that the absence of a minimum coverage requirement "would leave a gaping hole" in the regulatory scheme. *Raich*, 545 U.S. at 22. Thus, even if the means of payment for health care services were somehow not regarded as economic, it would nevertheless properly be regulated under the Affordable Care Act because Congress concluded that the "failure to regulate that class of activity would undercut the regulation of the interstate market[.]" *Id*. at 18.

Although insurance coverage is crucial to a consumer's ability to pay for health care services, escalating costs have made health insurance increasingly unaffordable. Between 1999 and 2010, average premiums for employer-sponsored family coverage increased 138 percent. Kaiser Family Foundation Employer Health Benefits, 2010 Annual Survey at 31, table 1.11 (2010). Since 2005, workers' contributions to premiums have gone up 47%, while wages increased 18%. Kaiser Family Foundation, Family Health Premiums Rise 3 Percent to $13,770 in 2010, But Workers' Share Jumps 14 Percent as Firms Shift Cost Burden (Sept. 2, 2010). These "[p]remium increases are driving people out of the insurance market." 47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance, 110th Cong. 49 (2008) (Prof.

Hall). As a result, between 2000 and 2009, the portion of the non-Medicare population covered by private insurance slipped from about 3/4 to about 2/3. Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). More than 50 million people — 18.8% of the non-elderly population — went without health insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8. That figure has increased dramatically since 1970, when only 6% of Americans under age sixty-five had no coverage. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding,* 14 J. Law & Policy 695, 710 (2006).

These trends are attributable in substantial part to the screening process known as "medical underwriting," in which eligibility and premium-levels are established on the basis of individual health status or history. As a result of medical underwriting, about 36% of applicants in the individual market are charged a substantially higher premium, denied coverage, or offered limited coverage that excludes pre-existing conditions. Department of Health and Human Services, Coverage Denied: How the Current Health Insurance System Leaves Millions Behind, at 1 (2009).

It is estimated that more than 57 million Americans have some pre-existing medical condition relevant to medical underwriting determinations. Families USA, Health Reform: Help for Americans with Pre-Existing Conditions 2 (2010); *see also* Memorandum on Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market to Members of the House Committee on Energy and Commerce from Chairmen Henry A. Waxman and Bart Stupak, at 1 (Oct. 12, 2010) (finding that, in the three years before the passage of the Affordable Care Act, the four largest for-profit health insurance companies denied over 600,000 individuals coverage because of pre-existing conditions, and that the number of coverage denials increased significantly each year).

Insurers often deny coverage even for relatively minor pre-existing conditions. Consumer Choices and Transparency in the Health Insurance Industry: Hearing Before the S. Comm. on Commerce, Science & Transp., 111th Cong. 29 (2009) (Karen Pollitz, Georgetown University Health Policy Institute). "In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage." 47 Million and Counting, 110th Cong. 52 (2008) (Prof. Hall). "The four largest for-profit health insurance companies . . . have each listed pregnancy as a medical condition that would result in an automatic denial of individual health insurance coverage."

Memorandum on Maternity Coverage in the Individual Health Insurance Market to Members of the House Committee on Energy and Commerce from Chairmen Henry A. Waxman and Bart Stupak, at 1 (Oct. 12, 2010).

The Act addresses these harsh underwriting practices by barring insurance companies from denying or revoking coverage or setting premiums based on medical condition. These guaranteed-issue and community-rating requirements would not work in a regulatory scheme that permits health care consumers to time their insurance purchases based on their current cost-benefit evaluations. Indeed, a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." 47 Million and Counting, Hearing Before the S. Comm. on Finance, 110th Cong. 52 (2008) (Prof. Hall).

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

The legislative record demonstrated that the absence of a minimum coverage requirement linked to guaranteed-issue and community-rating measures had undermined health care reform efforts in states such as New Jersey and New York.

In these circumstances, many consumers "will go without insurance when they are healthy, but then have the privilege of throwing themselves on the mercy of community-rated premiums when they fall ill." Making Health Care Work for American Families: Ensuring Affordable Coverage, Hearing Before the House Comm. on Energy and Commerce Subcomm. on Health, 111th Cong., at 11 (March 17, 2009) (testimony of Uwe Reinhardt, Princeton University). Citing the New Jersey experience, Professor Reinhardt explained that "[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." *Ibid.*; *see also* Monheit et al., *Community Rating & Sustainable Individual Health Insurance Markets in New Jersey*, 23 Health Affairs 167, 168 (2004); The Tax Code and Health Insurance Coverage, Hearing Before the House Budget Comm., 110th Cong., at 24 (Oct. 18, 2007) (Statement of Leonard Burman, Director, Tax Policy Center) (without a coverage requirement, "[t]he people who choose to buy insurance will tend to be those who expect to have the highest health care costs").

In the wake of similar legislation enacted in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & Law 71, 91-92 (2000). And when Maine enacted legislation requiring insurers to accept all

applicants and charge all policyholders in the same class the same premiums, most health insurers withdrew from the state, and rates offered by the state's remaining for-profit insurer increased. Health Reform in the 21st Century: Insurance Market Reforms, Hearing before the H. Comm. On Ways and Means, 111th Cong. 117 (2009) (Letter of Phil Caper, M.D. and Joe Lendvai).

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

Congress accordingly found that the minimum coverage requirement "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id*. § 18091(a)(2)(I). That determination, like Congress's determination regarding the costs of uncompensated care, is supported by a massive legislative record.

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

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

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

"The Federal '[g]overnment is acknowledged by all to be one of enumerated powers,'" but "at the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch v. Maryland*, 17 U.S. 316, 408 (1819)). Justice Scalia invoked this time-honored precept that undergirds the Necessary and Proper Clause in his concurring opinion in *Raich,* explaining that "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J.,

concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)).

Thus, "the relevant inquiry" under the Necessary and Proper Clause "is simply 'whether the means chosen are "reasonably adapted" to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S. Ct. at 1957 (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment) (quoting *United States v. Darby*, 312 U.S. 100, 121 (1941)). Accordingly, "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute," the Court asks "whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956 (citing *Sabri v. United States*, 541 U.S. 600, 605 (2004); *Raich*, 545 U.S. at 22; *Lopez*, 514 U.S. at 557; and *Hodel v. Virginia Surface Mining & Reclamation Assn.*, 452 U.S. 264, 276 (1981)).

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

The means chosen by Congress to effectuate the Affordable Care Act's regulatory goals were dictated by, and tailored to, the unique features of the market for health care services. Virtually all people, including the individual plaintiffs, participate in this market. In contrast to other markets, the timing and amount of expenditures are highly unpredictable and may not realistically involve an affirmative choice by the consumer. "Most medical expenses for people under 65" result "from the bolt-from-the-blue event of an accident, a stroke, or a complication of pregnancy that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." Statement of Professor Mark V. Pauly, Senate/House Joint Economic Committee (Sept. 22, 2004), 2004 WL 2107555.

When these events occur, people depend on the extensive medical infrastructure that is sustained in large part by the payments of the insured. Moreover, when the need for medical care arises, the cost may well dwarf other items in the individual's budget. *See* p.9, *supra*. In other markets, consumers have no expectation of receiving extraordinarily expensive services without regard to their ability to pay. But the opposite is true in the market for health care services. Federal and state law reflect the widely shared understanding that access to

medical treatment cannot properly be restricted in the same way as access to other goods and services.

Even before the enactment of the Emergency Medical Treatment and Active Labor Act in 1986, state courts and legislatures had responded to the changing role of private hospitals and of emergency rooms by creating tort liability for the failure to provide emergency services. The common law had long recognized limitations on a physician's ability to abandon treatment regardless of a patient's ability to pay, but recognized no duty on the part of private physicians to provide care in the first place. *Becker v. Janinski*, 15 N.Y.S. 675 (N.Y. Sup. 1891). The common law has evolved, however, to preclude hospitals from turning away patients with emergency needs because they are unable to pay for services. The "modern rule is that liability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency." *Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990). In addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985 "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists[.]" H.R. Rep. No. 99-241(III), at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 727.

These measures were not adequate, however, to prevent hospitals from diverting patients or discharging them prematurely. Congress thus enacted EMTALA in order "to prevent hospitals from dumping patients who suffered from an emergency medical condition because they lacked insurance to pay the medical bills." *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131, 1134 (6th Cir. 1990) (citing H.R. Rep. No. 99-241(I), at 27, *reprinted in* 1986 U.S.C.C.A.N. 42, 605). The federal statute augmented the duties imposed under state law by requiring all hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition without regard to ability to pay. 42 U.S.C. § 1395dd; *see also Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999) (per curiam).

Insurance requirements in the market for health care services thus cannot be imposed in the same way as a requirement to obtain automobile insurance. In both cases the requirement prevents externalization of costs. But while it is entirely acceptable for the government to make automobile insurance a condition for use of the highways, it would be entirely unacceptable to impose a similar requirement on the use of an emergency room. *See, e.g.*, Baicker & Chandra, *Myths and Misconceptions About U.S. Health Insurance*, 27 Health Affairs w533, w535 (2008) ("One of the many reasons that health insurance is different from car

insurance" is that "the underlying good, health care, is viewed by many as a right.").

Moreover, as noted, with health insurance, timing is critical. A health insurance market could never survive "if people could buy their insurance on the way to the hospital." 47 Million and Counting, at 14 (Prof. Hall). To be practical and ethical, a requirement to obtain medical insurance must therefore apply before the medical services are actually needed.

3. Plaintiffs' "inactivity" argument disregards their participation in the health care market and the teachings of the Supreme Court.

Plaintiffs repeatedly assert that they are not engaged in any activity that brings them within the reach of Congress's commerce power. This argument disregards their participation in the health care market and the teachings of the Supreme Court, which focus on whether Congress seeks to regulate interstate commerce, and if so, what it may do in furtherance of that regulation.

a. In *Raich*, the Supreme Court upheld the application of the Controlled Substances Act to the possession of marijuana that was grown at home for personal use. The Court reversed a court of appeals ruling that held that the plaintiffs were outside the scope of the commerce power because they had not entered the marijuana market. The court of appeals had incorrectly reasoned that "[t]he

cultivation, possession, and use of marijuana for medicinal purposes and not for exchange or distribution is not properly characterized as commercial or economic activity." *Raich v. Ashcroft*, 352 F.3d 1222, 1229 (9th Cir. 2003).

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

Raich reflected principles established more than half a century earlier in *Wickard v. Filburn*, 317 U.S. 111 (1942), which upheld the federal regulation of wheat that was grown and consumed on a family farm as part of a program to control the volume and price of wheat moving in interstate commerce. The Supreme Court sustained that exercise of the commerce power even though the wheat at issue was not "sold or intended to be sold," *id*. at 119, even though the home consumption of wheat by any individual "may be trivial by itself," *id*. at 127,

and even though the regulation "forc[ed] some farmers into the market to buy what they could provide for themselves," *id.* at 129.

Applying these holdings, this Court in *United States v. Bowers*, 594 F.3d 522 (6th Cir. 2010), upheld a child-pornography conviction based on the defendant's possession of photographs that he had taken in his home during visits by his daughter's friends. Although Bowers had not bought, sold, or distributed the photographs, the exercise of commerce power was valid because Congress could rationally conclude that possession for noncommercial purposes "if left unregulated in the aggregate, could work to undermine Congress's ability to regulate the larger interstate commercial activity." *Id.* at 529. Sustaining the conviction, this Court explained that "'Congress has a rational basis for believing that homegrown child pornography can feed the national market and stimulate demand.'" *Id.* at 528 (quoting *United States v. Chambers*, 441 F.3d 438, 455 (6th Cir. 2006)).

b. Plaintiffs seek to distinguish these cases by asserting that they "are not now engaged in any commercial or economic activity that affects in any way interstate commerce." Pl. Br. 30. They state: "This is because unlike *Wickard* and *Raich* [and other decisions] Plaintiffs are not engaged in any economic activity

whatsoever relative to the legislative findings of the Act or the regulatory scheme of the Act — essential or otherwise." *Ibid*.

This sweeping language reflects a cramped and illogical notion of "economic activity . . . relative to . . . the regulatory scheme of the Act." *Ibid*. Plaintiffs do not dispute that they are participants in the market for health care services. Their claim, instead, is that they are not currently in the market for health insurance. They declare that they "do not intend to engage in the commercial activity of purchasing health insurance," Pl. Br. 14, and prefer, instead, to "pay for health care expenses as [they] need them." R-7, Exhibit 4, ¶ 3 (DeMars Decl.); R-7, Exhibit 5, ¶ 3 (Hyder Decl.).

Plaintiffs focus on the wrong market and ignore what Congress sought to regulate. Even if plaintiffs do not currently participate in the *insurance* market, they indisputably participate in the market for health care services. Nothing required Congress to focus exclusively on the market that plaintiffs define, and nothing barred Congress from focusing on economic conduct in the health care market. Requirements to obtain insurance are not imposed because of participation in the insurance market itself; they are imposed because of concerns that individuals or corporations may be unable to meet costs resulting from activities in other markets. Under plaintiffs' logic, Congress would be constitutionally

precluded from applying any insurance requirement to anyone who is not already insured, on the theory that such people are not "active" in the insurance market — a proposition without support in precedent, practice, or common sense. Plaintiffs' position disregards the "broad principles of economic practicality" that underlie the commerce power. *Lopez*, 514 U.S. at 571 (Kennedy, J., concurring); *see also Wickard*, 317 U.S. at 120 ("questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' and foreclose consideration of the actual effects of the activity in question upon interstate commerce."); *Swift Co. v. United States*, 196 U.S. 375, 398 (1905) ("commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business"); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 336-337 (1962) (Congress chose in the Clayton Act to "prescribe[] a pragmatic, factual approach to the definition of the relevant market and not a formal, legalistic one").

c. Plaintiffs' attempt to draw an impermeable line separating participation in the health market from the maintenance of insurance coverage ignores the fundamental feature of health insurance — its function as the principal means of payment for health care services in the United States. Buying insurance reflects a choice of one method of dealing with the cost of potential medical expenses, in

preference to other options. Porat et al., *Market Insurance versus Self Insurance: The Tax-Differential Treatment and Its Social Cost*, 58 J. Risk & Ins. 657, 668 (1991) (buying insurance is an economic substitute for other "competing pre-loss risk-financing methods"). Those who resort to those other options may "use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services." Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. at 55. Implicitly or otherwise, these actions commonly reflect economic assessments of the relevant advantages of obtaining insurance versus other means of attempting to pay for health care services, although those assessments often ignore or underestimate the risks. Pauly, *Risks and Benefits in Health Care: The View From Economics*, 26 Health Affairs 653, 658 (2007).[4]

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[4] Professor Pauly notes that many consumers value more highly insurance that pays for medical costs that are likely to be incurred than insurance that provides inferior coverage for likely costs but superior coverage for catastrophic events. Pauly, *supra*, at 658. This reflects a significant distinction between health insurance and other types of insurance. The sole purpose of many types of insurance is to provide protection "against events that are highly unlikely to occur but involve large losses if they do occur." Milton Friedman, How To Cure Health Care, The Public Interest, Winter 2001, at 10. With regard to medical services, in contrast, "it has become common to rely on insurance to pay for regular medical examinations and often for prescriptions." *Ibid.*; *see also* Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. Pol. Econ. 251, 253 (1973) ("Health insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchases of health services.").

One way or another, those who participate in the health care market must determine whether and how they will pay for the services they receive. The district court recognized that, from both the societal and the individual perspective, "[t]he decision whether to purchase insurance or to attempt to pay for health care out of pocket, is plainly economic." R-28 at 16 (10/7/10 Order). "Regardless of whether one relies on an insurance policy, one's savings, or the backstop of free or reduced-cost emergency room services, one has made a choice regarding the method of payment for the health care services one expects to receive." *Liberty University Inc. v. Geithner*, __ F. Supp. 2d __ (W.D. Va. 2010), 2010 WL 4860299, *15.

Plaintiff DeMars, for example, has made the plainly economic calculation that it is in her immediate economic interest to pay for health care out-of-pocket, noting that she and her children are currently in good health. *See* R-18, Exhibit 1, ¶¶ 3-4 (Suppl. DeMars Decl.). Medical expenses can accumulate rapidly, however, and without warning, and DeMars does not suggest that she could find in her "already tight budget" the funds that would be needed to cover the full cost of a significant medical expense. *Id.* ¶ 7. If DeMars, or any other person who has made a similar calculation, encounters unexpected expenses for which they cannot pay, those costs will be externalized and borne by other consumers. Congress

acted well within its Commerce Clause power in regulating this economic decision that has profound economic effects on interstate commerce.

4. The Affordable Care Act bears no resemblance to the statutes held invalid in *Lopez* and *Morrison*.

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

The statutes at issue in *Lopez* and *Morrison* were stand-alone measures that involved no form of economic regulation. In *Lopez*, the Supreme Court struck down a ban on possession of a handgun in a school zone because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might undermine economic productivity. Similarly, in *Morrison*, the Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to connect gender-motivated violence with interstate commerce. Neither of these measures played any role in a broader regulation of economic activity. *Lopez*, 514 U.S. at 561. Indeed, the "noneconomic, criminal

nature of the conduct at issue was central" to the Court's decisions. *Morrison*, 529 U.S. at 610.

The minimum coverage provision is not a stand-alone measure. It is part of a broad economic regulation of health care financing in the massive interstate health care market, and it is essential to the Act's regulation of underwriting practices in the insurance industry. Nor does the minimum coverage provision regulate non-economic conduct. Rather, it addresses the means of payment for health care services in a market that accounts for one-sixth of the nation's GDP. Indeed, it is difficult to conceive of legislation that is more clearly economic than the regulation of the means of payment for health care services and the requirements placed on insurers, employers, and individuals who are made insurable by federal law. Far from the chain of attenuated reasoning required in *Lopez* and *Morrison* to identify any substantial effect on interstate commerce, the link to interstate commerce in this case is direct and compelling.

Perhaps more fundamentally, plaintiffs disregard the principal concern that animated *Lopez* and *Morrison*, which was to avoid a view of economic causation so broad that it would "obliterate the distinction between what is national and what is local in the activities of commerce." *Morrison*, 529 U.S. at 608 (quoting *Lopez*, 514 U.S. at 567) (other citations omitted). Plaintiffs do not contend that the

Affordable Care Act intrudes into an area of regulation that is reserved to the states. The problems that are addressed by the Act are by no means local. "The modern health care system is highly interdependent and operates across state boundaries." Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 New England J. Med. e29, at 3 (2010). "Furthermore, in a modern economy, people need to be able to move interstate in order to pursue economic opportunities and participate in a changing labor market." *Ibid*. "Affordable health care is a national problem that demands a national solution." *Ibid*. The minimum coverage provision, a quintessentially economic regulation, addresses national problems that arise in the context of a vast interstate market.

b. Plaintiffs' quarrel, at bottom, is not with the assertion of federal commerce power. In their view, the requirement to maintain minimum insurance portends a state of affairs in which "[l]iberty is no longer an unalienable right possessed by the individual[.]" Pl. Br. 13. Plaintiffs insist that, if the government may require such coverage, it "has the power, *a fortiori*, to require the same citizenry to act in specifically defined ways to safeguard their health in the first instance." Pl. Br. 12. Thus, they contend, "the federal government could mandate that we all join a health club and indeed impose on us a penalty for not actually

attending the club, to take multi-vitamins daily, and to dine only in government-approved 'health' restaurants." *Ibid*.

This rhetoric is not about interstate commerce. Insofar as the issue is "liberty," it would not matter whether the state or the federal government undertook the regulation. Plaintiffs would object — to take their own example — if a state government tried to tell them what they could eat. Such a claim would properly be analyzed under the Due Process Clause. Plaintiffs try to frame as a Commerce Clause claim what is, in reality, a different kind of substantive due process challenge for a violation of their economic liberty, a claim without legal support since the *Locher* era.

Imposing economic conditions on the purchase and sale of health care services is economic regulation of a national market. The minimum coverage provision is directed to such transactions and aims to ensure that purchasers will pay for, rather than shift to others, the costs of services that they obtain in that market — services that they need to have available at unknown times and in unknown amounts and that hospitals are generally required to render at times of greatest need. By contrast, plaintiffs' hypothetical requirement to eat in "health" restaurants would not regulate the financing of goods or services that people must have available at unexpected times and in unexpected amounts and that "health"

restaurants must provide, regardless of an individual's ability to pay. The minimum coverage provision restricts "economic freedoms," Pl. Br. 4, only in the sense that it curtails economic options to consume health care without insurance and to pass overwhelming costs on to other market participants.

Plaintiffs' rhetoric is particularly anomalous in light of Affordable Care Act provisions that confer real and significant benefits on people, like plaintiffs, who are not currently insured. The Act not only prevents plaintiffs from shifting their health care costs; it also guarantees that they are insurable and thus protects them from the risk of being left destitute by catastrophic medical expenses. *See* 42 U.S.C.A. § 18091(a)(2)(G) (62% of all personal bankruptcies are caused in part by medical expenses). "In 2014, the Act will bar insurers from refusing to cover individuals with pre-existing conditions and from setting eligibility rules based on health status or claims experience." R-28 at 18 (10/7/10 Order). "The uninsured, like plaintiffs, benefit from the 'guaranteed issue' provision in the Act, which enables them to become insured even when they are already sick." *Ibid*. Even apart from the many other rational bases for Congress's choice of means, "[t]his benefit makes imposing the minimum coverage provision appropriate." *Ibid*.

III. The Minimum Coverage Provision Is Independently Sustainable as a Valid Exercise of Congress's Taxing Power.

The Constitution vests Congress with the power to "lay and collect taxes," subject to specified constraints, including that all duties, imposts and excises shall be uniform throughout the United States and that "capitation" taxes be apportioned among the states. U.S. Const., art. I, § 2, cl. 3; *id.*, art. I, § 8, cl. 1; *id.*, art. I, § 9, cl. 4. The district court correctly upheld the minimum coverage provision as a valid exercise of Congress's commerce power, and thus did not need to decide whether the provision is also a valid exercise of Congress's taxing power.

As the district court explained, the Constitution's uniformity and apportionment requirements apply only to provisions that are enacted solely under Congress's taxing power, and do not apply to assessments that are enacted in aid of valid Commerce Clause legislation. R-28 at 19 (10/7/10 Order); *see also*, *e.g.*, *Rodgers v. United States*, 138 F.2d 992, 994 (6th Cir. 1943); *Board of Trustees of Univ. of Ill. v. United States*, 289 U.S. 48, 58 (1933); *United States v. Stangland*, 242 F.2d 843, 848 (7th Cir. 1957); *Moon v. Freeman*, 379 F.2d 382, 390-93 (9th Cir. 1967); *South Carolina ex rel. Tindal v. Block*, 717 F.2d 874, 887 (4th Cir. 1983); *Goetz v. Glickman*, 149 F.3d 1131, 1138 (10th Cir. 1998). Plaintiffs thus correctly concede that their "direct tax" argument is presented only "if this court

finds it even necessary to address the tax question." Pl. Br. 52. A ruling that Congress acted within its commerce power thus disposes of all plaintiffs' claims.

The commerce power, however, is not the only basis for rejecting plaintiffs' challenges. The minimum coverage provision is also a valid exercise of the taxing power, which has been described as "comprehensive," *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 581-82 (1937), and "plenary," *Murphy v. IRS*, 493 F.3d 170, 182-183 (D.C. Cir. 2007). It is settled that a tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States v. Sanchez*, 340 U.S. 42, 44 (1950). As long as a statute is "productive of some revenue," Congress may exercise its taxing powers irrespective of any "collateral inquiry as to the measure of the regulatory effect of a tax." *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937); *see also Bob Jones Univ. v. Simon*, 416 U.S. 725, 741 n.12 (1974) (noting that the Court has "abandoned" older "distinctions between regulatory and revenue-raising taxes"). In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941); *see also United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by

operation of Internal Revenue Code had "essential character as taxes" despite statutory label as "penalties").

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

There is no dispute that the minimum coverage provision will be "productive of some revenue." *Sonzinsky*, 300 U.S. at 514. The CBO estimated that $4 billion

in revenues will be derived each year from the provision when it is fully in effect. Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives, table 4 (Mar. 20, 2010). By adding a liability to be reported in the taxpayer's annual return and granting enforcement authority to the Secretary of the Treasury, the provision operates as a taxing measure. *See In re Chateaugay Corp*., 53 F.3d 478, 498 (2d Cir. 1995) ("the Coal Act was at least partially an exercise of the taxing power," given its placement in Internal Revenue Code and the grant of enforcement authority to the Treasury); *In re Leckie Smokeless Coal Co*., 99 F.3d 573, 583 (4th Cir. 1996) (same).

Plaintiffs contend that the minimum coverage provision cannot be justified under the taxing power unless Congress stated its intent to exercise that power. Pl. Br. 37. But "[t]he question of the constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise," *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948), even where, as here, Congress made findings relevant to the commerce power but not as to other enumerated powers. *See Timmer v. Mich. Dep't of Commerce*, 104 F.3d 833, 837, 840 (6th Cir. 1997) (Equal Pay Act is an exercise of the Fourteenth Amendment enforcement power, notwithstanding Commerce Clause findings in the statute); *In re Leckie Smokeless Coal Co.*, 99 F.3d at 576, 586 ("premium" on coal operators is

an exercise of taxing power despite Commerce Clause findings). In drafting the legislation, Congress repeatedly called the penalty a tax, and during the legislative debates, Congressional leaders explicitly defended the provision as an exercise of the taxing power. *See* 156 Cong. Rec. H1854, H1882 (Mar. 21, 2010) (Rep. Miller); 156 Cong. Rec. H1824, H1826 (Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (Dec. 22, 2009) (Sen. Leahy); 155 Cong. Rec. S13,558, S13,581-82 (Dec. 20, 2009) (Sen. Baucus); *see also* H.R. Rep. No. 111-443(I), at 265 (2010).

Plaintiffs also suggest that the taxing power cannot apply because § 5000A is phrased in terms of a "requirement" coupled with tax consequences for the failure to comply with that requirement. Pl. Br. 40. Other tax provisions are similarly phrased, however. *See, e.g.*, 26 U.S.C. § 527(i), (j); *id*. § 4980B; *id*. § 5761; *id*. §§ 9801-34; *see also Sonzinsky*, 300 U.S. at 511-512 (upholding registration requirement); *United States v. Thompson*, 361 F.3d 918, 920-21 (6th Cir. 2004) (upholding requirement and tax that "work[] hand-in-glove" together). To be sure, the taxing power may not be used to impose "punishment for an unlawful act." *United States v. LaFranca*, 282 U.S. 568, 572 (1931); *see also Dep't of Revenue of Mont. v. Kurth Ranch*, 511 U.S. 767, 781 (1994). But the minimum coverage provision does not impose "punishment." Indeed, a criminal

prosecution cannot lie for a failure to obtain coverage. 26 U.S.C.A. § 5000A(g)(2)(A). The provision does not punish a taxpayer retrospectively, but is instead imposed month-to-month for a failure to obtain coverage, with liability ending when coverage is obtained. *Id*. § 5000A(a)-(c). The amount of the assessment is capped at the greater of $695 or 2.5% of household income exceeding the filing threshold, *id*. § 5000A(c), and it can be no greater than the cost of qualifying insurance, *id*. § 5000A(c)(1)(B). Far from imposing punishment, the provision even has a "hardship" exemption. *Id*. § 5000A(e)(5).

Even if it is analyzed solely as an exercise of Congress's taxing powers, the minimum coverage provision is not subject to the apportionment requirement of Article I, Section 9 of the Constitution, which applies only to "capitation" and other "direct" taxes. This requirement applies only to a very narrow category of taxes; the Supreme Court has consistently construed the apportionment requirement to apply only to head or poll taxes, and taxes on property. *See Springer v. United States*, 102 U.S. 586, 602 (1880); *Veazie Bank v. Fenno*, 75 U.S. 533, 543 (1869); *Hylton v. United States*, 3 U.S. 171 (1796). Only a tax imposed on property, "solely by reason of its ownership," is a "direct tax." *Knowlton v. Moore*, 178 U.S. 41, 81 (1900). The minimum coverage provision does not impose a tax on property.

Nor does the provision impose a "capitation tax," which is one imposed "simply, without regard to property, profession, or any other circumstance." *Hylton*, 3 U.S. at 175 (opinion of Chase, J.); *Pac. Ins. Co. v. Soule*, 74 U.S. 433, 444-46 (1868) (adopting Justice Chase's definition); *Veazie Bank*, 75 U.S. at 544. Section 5000A does not impose a flat tax without regard to the taxpayer's circumstances. To the contrary, the penalty is assessed on a monthly interval, based on how the taxpayer elects to pay for health care services. 26 U.S.C.A. § 5000A(a), (b)(1). As discussed at length in the Commerce Clause argument, attempts to pay for health care without insurance have substantial adverse effects on interstate commerce. Accordingly, Congress taxed the failure to maintain a minimum level of insurance to cover health care costs, just as Congress previously has taxed failures to make other forms of economic arrangements. *See, e.g.*, 26 U.S.C. § 4974 (tax on failure of retirement plans to distribute assets); *id.* § 4980B (tax on failure of group health plan to extend coverage to beneficiary); *id.* § 4980E (tax on failure of employer to make comparable Archer MSA contributions); *id.* § 4942 (tax on failure of private foundation to distribute income).

The penalty for a failure to maintain minimum coverage does not apply to people with household income below the threshold for filing a return, or to people for whom the required contribution would exceed 8% of household income. *Id.*

§ 5000A(e)(1), (2). Moreover, the amount varies with the taxpayer's household income, subject to a floor of a particular dollar amount, and to a cap equal to the cost of qualifying coverage. *Id.* § 5000A(c)(1), (2).

In short, the variability in the application and amount of the penalty refutes any claim that it is a capitation tax.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted.

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CERTIFICATE OF COMPLIANCE WITH
FEDERAL RULE OF APPELLATE PROCEDURE 32(a)(7)(B)

I hereby certify that this brief complies with the type-face and volume limitations set forth in Federal Rule of Appellate Procedure 32(a)(7)(B) as follows: the type face is fourteen-point Times New Roman font, and number of words is 13,947.

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CERTIFICATE OF SERVICE

I hereby certify that on this 14th day of January, 2011, I caused the foregoing brief to be filed and served through the Court's CM/ECF system. All counsel of record are registered CM/ECF users.

/s/ Alisa B. Klein
Alisa B. Klein

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

Record Entry No.	Description
R-7	Plaintiffs' Motion for Preliminary Injunction
	Exhibit 4: Declaration of Plaintiff DeMars
	Exhibit 5: Declaration of Plaintiff Hyder
R-18	Plaintiffs' Reply to Defendants' Response to Motion for Preliminary Injunction
	Exhibit 1: Supplemental Declaration of Plaintiff DeMars
R-28	Order Denying Plaintiffs' Motion for Preliminary Injunction and Dismissing Plaintiffs First and Second Claims for Relief
R-29	Stipulated Order Dismissing Remaining Claims without Prejudice