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Virginia v. Sebelius - U.S. Brief for Appellant

U.S. Department of Health and Human Services

Nos. 11-1057 & 11-1058

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

COMMONWEALTH OF VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II,
in his official capacity as Attorney General of Virginia,
Plaintiff-Appellee/Cross-Appellant,

v.

KATHLEEN SEBELIUS, Secretary of the Department of Health and
Human Services, in her official capacity,
Defendant-Appellant/Cross-Appellee.

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

BRIEF FOR APPELLANT

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases: **Page**

Constitution:

Statutes:

Legislative Materials:

STATEMENT OF JURISDICTION

Plaintiff invoked the district court's jurisdiction under 28 U.S.C. § 1331. The court entered final judgment on December 13, 2010. Both parties filed notices of appeal on January 18, 2011. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

Virginia seeks to challenge the minimum coverage provision of the Patient Protection and Affordable Care Act ("Affordable Care Act"), which, when it takes effect in 2014, will require non-exempted individuals to maintain a minimum level of health insurance or pay a tax penalty. The questions presented are:

1. Whether the district court erred in holding that Virginia could establish standing to challenge the minimum coverage provision by enacting a law that declares that no Virginia resident "shall be required to obtain or maintain" an individual insurance policy.

2. Whether the district court erred in holding that the minimum coverage provision is not a valid exercise of Congress's commerce power.

3. Whether the district court erred in holding that the minimum coverage provision is not a valid exercise of Congress's taxing power.

STATEMENT OF THE CASE

1. The Commonwealth of Virginia seeks to challenge a federal law, based on a Virginia statute that declares the Commonwealth's disagreement with that law. The federal law that Virginia challenges, the Affordable Care Act, is a comprehensive reform of our national health care system. The Act seeks to ameliorate the longstanding crisis in the interstate market for health care services that accounts for more than 17% of the nation's gross domestic product. In enacting the law, Congress found that private health insurance spending was projected to be $854 billion in 2009.

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

The Affordable Care Act addresses these national and interstate problems, which individual states are unable to handle comprehensively, through a series of

measures that will make affordable health care coverage widely available, protect consumers from restrictive insurance underwriting practices, and reduce the uncompensated costs of medical care obtained by the uninsured, which are otherwise borne by others in the health care market.

The minimum coverage provision at issue in this suit requires non-exempted individuals to maintain a minimum level of health insurance coverage or pay a tax penalty. 26 U.S.C.A. § 5000A. In enacting this provision, Congress made detailed findings addressed to the standards established by the Supreme Court for assessing whether Congress has acted within its commerce power. Congress found that the Act's minimum coverage requirement regulates "economic and financial decisions about how and when health care is paid for," 42 U.S.C.A. § 18091(a)(2)(A); that the consumption of health care without insurance has substantial adverse effects on the interstate health care market, *id*. § 18091(a)(2)(F); that health insurance "pays for medical supplies, drugs, and equipment that are shipped in interstate commerce," "is sold in interstate commerce and claims payments flow through interstate commerce," *id*. § 18091(a)(2)(B); and that the minimum coverage requirement is "essential" to the Act's insurance reforms that prevent insurers from denying coverage or charging higher premiums because of an individual's medical condition or history, *id*. § 18091(a)(2)(I).

2. Virginia filed this suit the day the Affordable Care Act was signed into law, alleging that Congress lacked authority to enact the minimum coverage provision. To demonstrate standing, Virginia cited a new state statute declaring that no Virginia resident "shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services where an individual is named a party in a judicial or administrative proceeding." Virginia Code § 38.2-3430.1:1 (2010). Virginia alleged that the minimum coverage provision "imposes immediate and continuing burdens on Virginia" by creating a "collision" with this state law, which Virginia refers to as the "Virginia Health Care Freedom Act." JA 29.

The federal government moved to dismiss for lack of standing. The district court denied the motion, opining that "states have an interest as sovereigns in exercising 'the power to create and enforce a legal code,'" and that Virginia may bring this suit "to defend the Virginia Health Care Freedom Act from the conflicting effect of an allegedly unconstitutional federal law." JA 308.

On cross-motions for summary judgment, the court held that the minimum coverage provision is not a valid exercise of either Congress's commerce power or its taxing power. Addressing the commerce power, the court did not question Congress's finding that consumption of health care services without insurance

imposes a substantial burden on the interstate health care market. Nor did the court question Congress's finding that the minimum coverage provision is instrumental to the Act's other reforms that bar insurance companies from denying coverage because of pre-existing medical conditions (a requirement known as "guaranteed issue") and from charging higher premiums based on a person's medical history (a requirement known as "community rating"). The court declared, however, that, under the Commerce Clause, Congress can regulate only economic activity, and that regulation of the means of payment for health care services is not regulation of economic activity. The court opined that defining economic activity to include regulation of how people pay for health care "lacks logical limitation and is unsupported by Commerce Clause jurisprudence." JA 1097.

Addressing the taxing power, the court recognized that the minimum coverage provision amends the Internal Revenue Code to provide that non-exempted individuals who fail to maintain minimum coverage shall pay a penalty that is calculated in part by reference to household income, reported on the individual's federal income tax return for the taxable year, and assessed and collected in the same manner as certain other federal tax penalties. JA 1100-01. The court acknowledged the Congressional Budget Office ("CBO") projection that this provision will generate billions of dollars of revenue each year paid into the general treasury. JA 1100.

Nonetheless, the court held that the provision is not a valid exercise of the taxing power because the "legislative purpose underlying this provision was purely regulation of what Congress misperceived to be economic activity." JA 1106.

The district court issued a declaratory judgment holding the minimum coverage provision unconstitutional. The court severed the provision and "directly-dependent provisions which make specific reference" to it from the remainder of the Affordable Care Act, JA 1114, and denied injunctive relief, JA 1115. Both parties appealed.[1]

STATEMENT OF FACTS

I. Background

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

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

[1] The government does not challenge the court's Anti-Injunction Act ruling.

provide — emergency care without regard to an individual's ability to pay. The market is also unique in that individuals typically pay for health care services through private or government insurance.

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

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

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

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

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

of the non-elderly U.S. population (156.2 million people) had employer-based health insurance in 2009. Holahan, *The 2007-09 Recession And Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011). In that year, about 5.2% of the non-elderly population (13.8 million people) had policies purchased in the individual insurance market. *Ibid*.

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

As these figures indicate, the federal government's involvement in the system of health care financing is pervasive. In 2009, federal spending on Medicare and Medicaid was around $750 billion, with billions more funding other federal programs. CBO, The Long-Term Budget Outlook, at 29-30 (2010). These figures do not include

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

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

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

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

Health Statistics Health Statistics for U.S. Children: National Health Interview Survey, 2009, table 16 (2010) (18% of uninsured children visited the emergency room in 2009).

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

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

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

Insurance Coverage, 30 Health Affairs 145, 148 (2011). The percentage covered by employment-based plans, 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 applicants' medical condition and history to determine eligibility and premiums, a process known as "medical underwriting." CBO, Key Issues at 8, 80. A recent national survey estimated that 12.6 million non-elderly adults — 36% of those who tried to purchase health insurance in the previous three years in the individual insurance market — were denied coverage, charged a higher rate, or offered limited coverage because of a pre-existing condition. Department of Health and Human Services ("HHS"), Coverage Denied: How the Current Health Insurance System Leaves Millions Behind (2009).

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

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

II. The Affordable Care Act

The Affordable Care Act addressed problems in the national health care system that states individually have proven unable to solve effectively. Through comprehensive reforms, the Act will make health care coverage widely available and affordable, protect consumers from insurance industry underwriting practices, and reduce the uncompensated care that shifts costs to other participants in the interstate health care market and thereby increases the premiums for insured consumers. In so doing, the Act also removes obstacles to interstate commerce, such as the reluctance of workers to take new jobs for fear of losing employee health insurance benefits.

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

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

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

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

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

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

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

The CBO has projected that the Act will reduce the number of non-elderly people without insurance by about 33 million by 2019. Letter from Douglas W. Elmendorf to John Boehner, Speaker, U.S. House of Representatives (Feb. 18, 2011).

SUMMARY OF ARGUMENT

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

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

I. Like the individual plaintiffs in *Liberty University v. Geithner*, No. 10-2347, the Commonwealth challenges Congress's authority to enact the minimum coverage provision, which will require that non-exempted individuals maintain a minimum level of insurance or pay a tax penalty. The Commonwealth, however, lacks standing to sue. The minimum coverage provision applies only to individuals, not to the Commonwealth, and Supreme Court precedent forecloses a suit by a state "to protect her citizens from the operation of federal statutes." *Massachusetts v. EPA*, 549 U.S. 497, 520 n.17 (2007).

Contrary to the district court's reasoning, the Commonwealth cannot overcome this bar to *parens patriae* standing by enacting a law "to protect her citizens from the operation of federal statutes," *ibid*., and then suing to defend that law. The state law that Virginia invokes does no more than declare federal law unenforceable against Virginia residents. It does not establish a legal code. It does not impose duties on Virginia residents. It grants the Commonwealth no enforcement powers. And it has no more effect than a resolution declaring the sense of the legislature. Indeed, the district court acknowledged the "declaratory nature" of the state law. JA 308. Whether the Commonwealth frames its disagreement with federal law in a complaint or first proclaims it in a legislative enactment, the suit impermissibly calls upon the Court "to adjudicate, not rights of person or property, not rights of dominion over

physical domain, not quasi sovereign rights actually invaded or threatened, but abstract questions of political power, of sovereignty, of government." *Massachusetts v. Mellon*, 262 U.S. 447, 484-85 (1923).

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

Fundamental features of the legislation and the health care market are not in dispute. Health care providers and insurers operate interstate. Virtually all Americans participate in the health care market. The need for expensive health care services is unpredictable, and people who endeavor to pay for such services without insurance do not, as a class, pay the full cost of the services they obtain.

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

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

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

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

The end that Congress seeks to address here is undoubtedly legitimate because consumption of health care services without insurance has demonstrable and harmful effects on other participants in the interstate health care market. The means that Congress adopted to achieve that end are proper and 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 when they will need expensive health care services or the extent of their need. When that need arises, individuals depend on the extensive medical infrastructure financed and sustained by other participants in the health care services market.

The cost of those services can easily exceed the consumer's ability to pay. Nevertheless, unlike in other markets, consumers can and do receive expensive medical treatment for which they do not pay. Congress had far more than a rational basis for its findings that such consumption of health care services without insurance substantially affects interstate commerce, that the minimum coverage requirement will restrict shifting of costs to other market participants, and that it will be instrumental in effectuating a comprehensive regulatory scheme based on guaranteed issue and community rating.

C. 1. The district court did not question these congressional determinations. It concluded, however, that the minimum coverage provision exceeds Congress's power because, in the court's view, it impermissibly "compel[s] an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market." JA 1098. This analysis misconceives the nature of the regulated market and the governing Commerce Clause principles. People who attempt to pay for health care services out-of-pocket are no less "in the stream of commerce" than people who pay

with insurance. Further, when people consume health care without insurance to pay for it, others in the market bear its costs. The minimum coverage requirement is not an end in itself; it is a means of regulating the health care market. To disregard the role of insurance as the primary means of payment for health care services is to disregard the teachings of the Supreme Court, which has rejected artificial distinctions in favor of "broad principles of economic practicality." *United States v. Lopez*, 514 U.S. 549, 568-75 (1995) (Kennedy, J., concurring).

The district court's insistence that congressional authority must be triggered by "some type of self-initiated action," JA 1098, disregards economic practicalities and improperly divorces participation in the health care market from the means of payment for services in that market. A requirement to purchase insurance to avoid externalization of costs is hardly novel. The court believed, however, that Congress could not "requir[e] advance purchase of insurance based upon a future contingency," JA 1097, *i.e.*, the consumption of health care services. But use of the health care system is "contingent" only to the extent that the timing of health care needs is unpredictable. In the case of automobile insurance, the risks addressed by insurance coverage arise with possession of a car, and an insurance requirement can thus reasonably be linked to car registration. The risks addressed by health insurance, in contrast, do not arise in conjunction with "self-initiated action." Nor was Congress

required to link the insurance requirement to a specific acquisition of medical services. A patient demanding emergency medical services surely presents the type of "self-initiated action" that is within Congress's regulatory authority. It is equally clear, however, that broadly accepted moral principles and pragmatic realities, reflected in federal and state law, preclude Congress from framing the insurance requirement as a condition of access to the nation's emergency rooms. The timing of the minimum coverage requirement, like the other features of the provision, is thus adapted to the unique features of the health care market.

2. The district court's decision finds no support in *Lopez* or *Morrison*, the two modern Supreme Court decisions holding that Congress exceeded its commerce power. Those decisions sought to preserve "a distinction between what is truly national and what is truly local." *United States v. Morrison*, 529 U.S. 598, 617-618 (2000) (quoting *Lopez*, 514 U.S. at 567-568). The district court did not and could not suggest that regulation of the interstate health care and health insurance markets — which have long been subject to federal regulation — intrudes upon an exclusive domain of the states.

The modern health care system operates across state boundaries. Most health insurance is sold or administered by national or regional companies that operate interstate, and it pays for medical supplies shipped in interstate commerce. Further,

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

III. The minimum coverage provision is also independently authorized by Congress's taxing power. In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941). The minimum coverage provision appears in the Internal Revenue Code and operates as a tax. It is projected to raise billions of dollars in revenue each year. Contrary to the district court's understanding, the validity of the assessment does not turn on whether it is labeled a "tax." The Constitution itself uses several different terms to refer to the concept of taxation.

STANDARD OF REVIEW

The district court's standing and merits rulings are subject to *de novo* review. *United States v. Malloy*, 568 F.3d 166, 179 (4th Cir. 2009); *Wilmington Shipping Co. v. New England Life Ins. Co.*, 496 F.3d 326, 333 (4th Cir. 2007).

ARGUMENT

I. Virginia Lacks Standing to Challenge the Minimum Coverage Provision.

The minimum coverage provision applies only to "individual[s]," 26 U.S.C. § 5000A(a), not states. It thus may be challenged by individuals who meet the usual standing requirements, such as the Virginia residents suing in *Liberty University*. Longstanding rules governing *parens patriae* standing, however, prohibit the Commonwealth from litigating against the United States on its citizens' behalf. That Virginia has enacted its own statute for the sole purpose of declaring federal law a nullity does not alter the standing analysis.

Virginia rests its claim of standing on its enactment of Virginia Code § 38.2-3430.1:1, shortly before the Affordable Care Act was signed. The statute declares that no Virginia resident "shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the [Virginia] Department of Social Services." The statute applies to no entities other than the federal government. It grants the Commonwealth no enforcement powers. Virginia

has not suggested that it serves any function other than purportedly to create standing here. Indeed, the statute exempts entities other than the federal government, allowing a higher education institution, for example, to require health insurance as a condition of enrollment.

To attempt to establish standing, Virginia asserts that the federal statute creates a "collision" with its own law, JA 29, that it "has an interest in asserting the validity" of its enactment, JA 30, and that the state law "is valid despite the Supremacy Clause of the United States Constitution" because the minimum coverage provision is unconstitutional, JA 30.

But Virginia cannot circumvent the bar to *parens patriae* standing by means of a statute that purports to preclude application of federal law. Insofar as Virginia asserts any cognizable rights, they are the rights of its residents. The Supreme Court has long held, however, that "[a] State does not have standing as *parens patriae* to bring an action against the Federal Government." *Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 610 n.16 (1982) (citing *Massachusetts v. Mellon*, 262 U.S. 447, 485-86 (1923), and *Missouri v. Illinois*, 180 U.S. 208, 241 (1901)). As the Supreme Court explained in *Mellon*, the citizens of a state "are also citizens of the United States," and "[i]t cannot be conceded that a state, as *parens patriae*, may institute judicial proceedings to protect citizens of the United States from the operation

of the statutes thereof." *Mellon*, 262 U.S. at 485. The Court stressed that "it is no part of [a State's] duty or power to enforce [its citizens'] rights in respect of their relations with the federal government." *Id*. at 485-86. "In that field it is the United States, and not the state, which represents them as *parens patriae*." *Id*. at 486.

These principles control here. As in *Mellon*, this Court is "called upon to adjudicate, not rights of person or property, not rights of dominion over physical domain, not quasi sovereign rights actually invaded or threatened, but abstract questions of political power, of sovereignty, of government." *Mellon*, 262 U.S. at 484-85. And, as the Supreme Court held in *Mellon*, such assertions do not present a justiciable issue. The Commonwealth's suit falls squarely within the rule that a *parens patriae* suit "in which [a] state asserts [an] injury to [the] well-being of its populace ... cannot be maintained against the Federal Government." *Hodges v. Abraham*, 300 F.3d 432, 444 (4th Cir. 2002); *see also New Jersey v. Sargent*, 269 U.S. 328, 337 (1926) (allegation that provisions of federal law "go beyond the power of Congress and impinge on that of the state ... do not suffice as a basis for invoking an exercise of judicial power"). Virginia's declaratory statute is immaterial; the Supreme Court would not have reached a different conclusion in *Mellon* if the state had first incorporated its complaint into a statute declaring that no Massachusetts citizen could be required to pay federal taxes to support the challenged federal program.

The district court's contrary ruling rested on a basic misunderstanding of *Alfred L. Snapp*, in which Puerto Rico sued a private employer for discriminating against Puerto Rican residents in violation of federal law. The Court held that Puerto Rico had standing to sue the private employer as *parens patriae*, 458 U.S. at 609-10, and also found an independent interest "in securing residents from the harmful effects of discrimination," observing that "[t]his Court has had too much experience with the political, social, and moral damage of discrimination not to recognize that a State has a substantial interest in assuring its residents that it will act to protect them from these evils." *Id.* at 609.

That holding regarding a suit by a state against a private party has no bearing on this suit by a state against the federal government. In its sole reference to suits brought by a state against the United States, *Snapp* reaffirmed the settled limits on state standing. The Court noted that, unlike the plaintiffs in cases such as *Mellon*, Puerto Rico was "seeking to secure the federally created interests of its residents against private defendants." *Id.* at 610 n.16. The Court did not remotely suggest that a state can convert a "naked contention that Congress has usurped the reserved powers of the several states," *Mellon*, 262 U.S. at 483, into a justiciable controversy by codifying its legal claim before filing it. JA 308.

If that were the case, a state could generate standing to challenge a federal law merely by passing a state law to contradict it, even if such a law were purely declarative of the state's disagreement with the federal legislation at issue. *See* JA 308 (acknowledging the "declaratory nature" of the Virginia law). For example, under Virginia's theory, if its legislature concluded that Social Security taxes were unconstitutional, it could pass a statute purporting to exempt its citizens from their federal obligations and then sue the United States based on the Commonwealth's alleged sovereign interest in the vitality of its law. Similarly, the state might object to deployment of military forces in a particular armed conflict, enact a statute purporting to exempt its residents from military service in the conflict, and then sue the United States. Long-established standing requirements preclude such litigation, and that bar cannot be circumvented through the enactment of state declaratory laws. States may agree or disagree with a range of federal policies, and these disputes are resolved in the political arena, not the courts.

Comparison with cases in which the Supreme Court has found state standing to sue the federal government confirms that the controversy here is not justiciable. For example, in *Massachusetts v. EPA*, 549 U.S. 497, 522–23 (2007), the Court held that the state could challenge EPA's failure to regulate greenhouse gas emissions because "rising seas," caused in part by these emissions, would injure Massachusetts "in its

capacity as a landowner" and "have already begun to swallow Massachusetts' coastal land." A state likewise may challenge a measure that commands the state to take action, *e.g.*, *New York v. United States*, 505 U.S. 144 (1992) (federal law required state to take title to nuclear waste or enact federally-approved regulations), or that prohibits specified state action, *e.g.*, *Oregon v. Mitchell*, 400 U.S. 112 (1970) (federal law prohibited literacy tests or durational residency requirements in state elections).

The Commonwealth's suit has none of these features. Nor is this a case in which federal action "interferes with [a State's] ability to enforce its legal code." *Wyoming ex rel. Crank v. United States*, 539 F.3d 1236, 1242 (10th Cir. 2008). It may be assumed that, in some circumstances, a state may have standing to challenge federal action that significantly disrupts that state's own regulatory scheme. The Virginia statute, however, serves no purpose other than as a tool for standing here: if the minimum coverage provision is unconstitutional, the statute is unnecessary, and if the minimum coverage provision is upheld, the state statute is void under the Supremacy Clause. Supreme Court precedent does not permit suits to assert such an abstract interest. As the Court stressed in *Massachusetts v. EPA*, "there is a critical difference between allowing a State 'to protect her citizens from the operation of federal statutes' (which is what *Mellon* prohibits) and allowing a State to assert its rights under federal

law (which it has standing to do)." 549 U.S. at 520 n.17.[4] The only objective of the Virginia statute is "to protect her citizens from the operation of federal statutes." *Ibid*. Supreme Court precedent forecloses the Commonwealth's invitation to adjudicate the "antagonistic assertions of right," JA 29, that are the sole basis for this suit.

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

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

[4] On this point, the Court was unanimous. Chief Justice Roberts, joined by Justices Scalia, Thomas, and Alito, would have held that *Mellon* precluded standing. 549 U.S. at 539 (Roberts, C.J., dissenting). Indeed, the Chief Justice suggested that the state's "true goal for this litigation may be more symbolic than anything else. The constitutional role of the courts, however, is to decide concrete cases — not to serve as a convenient forum for policy debates." *Id*. at 547.

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

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

Congress's findings and the legislative record leave no doubt that the minimum coverage provision — which regulates the means of payment for services in the

interstate health care market — "regulates activity that is commercial and economic in nature," 42 U.S.C.A. § 18091(a)(2)(A), and that has an enormous impact on interstate commerce. First, the minimum coverage provision addresses the consumption of health care services without payment, which is indisputably activity that shifts billions of dollars of costs annually to other participants in the interstate health care market and to the federal government and states. *Id*. § 18091(a)(2)(F). These costs are spread across state lines because many insurance companies operate in multiple states. *Id*. § 18091(a)(2)(B). Second, the provision is instrumental to the viability of the statute's regulation of medical underwriting, which guarantees individuals that they will be insurable regardless of illnesses or accidents, and will not be charged higher premiums on account of health status or history. *Id*. § 18091(a)(2)(I), (J).

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

The interstate nature of the market for health care services is not disputed. Nor is it controverted that, as a class, Americans participate in the market for health care services whether or not they have health insurance. *See* pp.10-11, *supra*. The uninsured population does not, however, bear the full cost of its participation. A 2005 study found that, even in households at or above median income, uninsured people on

average pay for less than half the cost of the medical care they consume. Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. Health Econ. 225, 229-30 (2005). Moreover, they pay a diminishing percentage of their costs as their consumption of medical services increases. *Ibid*.

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

Congress determined that this cost-shifting inflates premiums that families pay for their health insurance "by an average of over $1,000 a year." *Ibid*.; *see also* 156 Cong. Rec. E506-01, 2010 WL 1133757 (Rep. Waxman) (Mar. 25, 2010). In California, for example, an estimated 10% of health insurance premiums is attributable to uncompensated care consumed by people without insurance. S. Rep. No. 111-89, at 2 (2009).

Supreme Court precedents make clear that it is irrelevant whether a particular individual's consumption of health care services without insurance will impose a

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

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

The minimum coverage provision is also valid Commerce Clause legislation because it is an integral part of the broader statutory scheme, which requires that insurers extend coverage and set premiums without regard to pre-existing medical conditions.

Learning from the experience of state regulators, Congress recognized that an effective system of guaranteed issue and community rating is unsustainable if participants in the health care market can postpone purchasing insurance until an acute need arises. Congress accordingly concluded that the absence of a minimum coverage requirement "would leave a gaping hole" in the regulatory scheme. *Raich*, 545 U.S. at 22. Thus, even if the means of payment for health care services were not regarded as economic, regulation would nevertheless be proper because Congress found that the "failure to regulate that class of activity would undercut the regulation of the interstate market." *Id*. at 18; *see also id*. at 37-38 (Scalia, J., concurring in the judgment) (noting that, in *United States v. Darby*, 312 U.S. 100 (1941), the Court upheld employer record-keeping requirements for intrastate transactions as an appropriate means to ensure compliance with its regulation of interstate commerce); *Hoffman v. Hunt*, 126 F.3d 575, 587 (4th Cir. 1997) (Congress could restrict efforts to obstruct access to reproductive health care facilities because the regulated activity "while not itself economic or commercial, is closely and directly connected with an economic activity").

The nation faces an acute shortage of affordable health insurance. More than 50 million Americans went without insurance in 2009. Census Bureau Report, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23, table 8.

Rising premiums priced many people out of the market. Between 1999 and 2010, for example, average premiums for employer-sponsored family coverage increased 138 percent. Kaiser Family Foundation Employer Health Benefits, 2010 Annual Survey at 31, table 1.11 (2010).[5]

Many others are excluded as a result of a screening process known as "medical underwriting," in which insurers establish coverage eligibility and premium levels based on individual health status or history. About 36% of non-elderly adult applicants in the individual market are denied coverage, charged a substantially higher premium, or offered limited coverage because of pre-existing conditions. HHS, Coverage Denied, at 1. Depending on the definition used, between 50 and 129 million non-elderly Americans (or 19 to 50% of the non-elderly population) have at least one pre-existing condition, and more than 600,000 individuals were excluded by the four largest for-profit insurers in the three years before the Affordable Care Act was enacted. HHS, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans (2011); Chairman Henry A. Waxman and Rep. Bart Stupak, Memorandum on

[5] The number of persons without insurance 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).

Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market to H. Comm. on Energy and Commerce, at 1 (Oct. 12, 2010).

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

The Act ends these restrictive underwriting practices, barring insurers from denying coverage or setting premiums based on medical condition. Congress found that these guaranteed-issue and community-rating requirements would not work without a minimum coverage provision to prevent health care consumers from waiting to buy insurance until they are sick or injured. 42 U.S.C.A. § 18091(a)(2)(I). A "health insurance market could never survive or even form if people could buy their

insurance on the way to the hospital." 47 Million and Counting, 110th Cong. 52 (Prof. Hall). Congress thus found the provision "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." 42 U.S.C.A. § 18091(a)(2)(J).

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

In the wake of similar legislation in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & Law 71, 91-92 (2000). And when Maine enacted similar legislation, most insurers withdrew from the state. Health Reform in the 21st Century: Insurance Market Reforms, Hearing Before the H. Comm. on Ways and Means, 111th Cong. 117 (2009) (Letter of Phil Caper, M.D., and Joe Lendvai).

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

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

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.

The Commonwealth does not dispute that people who obtain health care services without insurance shift substantial costs to other market participants; nor does it dispute the centrality of the minimum coverage provision to the Affordable Care Act's broader regulation of medical underwriting. Instead, the Commonwealth challenges the means Congress chose to regulate payment in the interstate market for health care services. Governing precedent leaves no room to override Congress's judgment about the appropriate means to achieve its legitimate objectives.

"[T]he Federal '[g]overnment is acknowledged by all to be one of enumerated powers,'" but, "at the same time, 'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 405, 408). Justice Scalia invoked this time-honored precept when he observed that the "regulation of an intrastate activity may be essential to a comprehensive regulation of interstate commerce even though the intrastate activity does not itself 'substantially affect' interstate commerce." *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment). "Moreover, as ... *Lopez* ... suggests, Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce." *Ibid*. (citing *Lopez*, 514 U.S. at 561). Where "Congress has the authority to enact a regulation of interstate commerce, 'it possesses every power needed to make that regulation effective.'" *Id*. at 36 (quoting *United States v. Wrightwood Dairy Co*., 315 U.S. 110, 118-19 (1942)).

Thus, "the relevant inquiry" under the Necessary and Proper Clause "is simply 'whether the means chosen are "reasonably adapted" to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S. Ct. at 1957 (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment) (quoting *Darby*, 312 U.S. at

121)). Accordingly, "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute," the Court asks "whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Id*. at 1956.

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

The means chosen by Congress to effectuate the Affordable Care Act's regulatory goals respond to, and are closely tailored to, the unique features of the market for health care services: participation is essentially universal; the need for medical treatment may arise unexpectedly and not as a matter of choice; the cost of care may overwhelm the typical family budget; and, in many cases, an individual can expect to receive expensive medical services without regard to his ability to pay.

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

highways, it would be entirely unacceptable to impose a comparable requirement on the use of an emergency room.

Even before enactment of EMTALA in 1986, state courts and legislatures had responded to the changing role of private hospitals and of emergency rooms by creating tort liability for the failure to provide emergency services. The common law had long limited a physician's ability to abandon treatment regardless of patients' ability to pay, but recognized no duty on the part of private physicians to provide care in the first place. *Becker v. Janinski*, 15 N.Y.S. 675 (N.Y. Sup. 1891). The common law evolved, however, to preclude hospitals from turning away patients with emergency needs because they are unable to pay for services. Thus, the Delaware Supreme Court held in 1961 that "liability on the part of a hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency." *Wilmington General Hospital v. Manlove,* 174 A.2d 135, 140 (Del. 1961); *see also Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) ("modern rule" is "that liability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency"). In addition to "state court rulings impos[ing] a common law duty on doctors and hospitals to provide necessary emergency care," by 1985, "at least 22 states [had] enacted statutes or issued regulations requiring the provision of limited medical services whenever an

emergency situation exists." H.R. Rep. No. 99-241(III) (1985), at 5, *reprinted in* 1986 U.S.C.C.A.N. 726, 727.

These measures were inadequate, however, to prevent "hospital emergency rooms [from] refusing to treat patients with emergency conditions if the patient does not have medical insurance.'" H.R. Rep. No. 99-241(I), at 27. Congress thus enacted EMTALA "to address a growing concern with preventing 'patient dumping,' the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions were stabilized." *Vickers v. Nash General Hospital*, 78 F.3d 139, 142 (4th Cir. 1996). The federal statute augmented state law by requiring all hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, without regard to ability to pay. 42 U.S.C. § 1395dd; *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999).

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

custodians when holding it "necessary and proper" for Congress to confine a federal prisoner whose mental illness threatens others).

3. Congress can regulate participants in the health care services market even if they do not currently maintain insurance coverage.

a. The district court recognized that Congress's authority "even extends to noneconomic activity closely connected to the intended market," JA 1097-98 (citing *Hoffman,* 126 F.3d at 587-88), but held that Congress's regulatory authority must be "triggered by some type of self-initiated action." JA 1098. The court declared that the minimum coverage provision exceeds Congress's commerce power because, in the court's view, the provision "compel[s] an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market." *Ibid.*

This reasoning misapprehends the nature of the regulatory scheme. The court did not dispute that "the individuals subject to [the minimum coverage provision] are either present or future participants in the national health care market." *Mead v. Holder*, __ F. Supp. 2d __ (D.D.C. 2011), 2011 WL 611139, *18 (citing *Liberty University Inc. v. Geithner*, __ F. Supp. 2d __ (W.D. Va. 2010), 2010 WL 4860299, *15; *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010)). Individuals do not remove themselves from the health care market or "the stream of commerce" by attempting to pay for services out of pocket rather than with

insurance. Congress may regulate the conduct of participants in the health care market even if the participants are "inactive" in the insurance market. Thus, even assuming *arguendo* that the minimum coverage provision could be thought to regulate inactivity, Congress is not regulating inactivity "as such," *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment), but as an aspect of its regulation of active participation in the health care market.

The district court's circumscribed notion of Congress's power echoes arguments repeatedly rejected by the Supreme Court. In *Raich*, the Court upheld the application of the Controlled Substances Act to the possession of marijuana that was grown at home for personal use. The Court found it irrelevant that the individuals were not engaged in commercial activity and did not buy, sell, or distribute any portion of the marijuana they possessed. The regulation was proper 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*, which upheld federal regulation of wheat grown and consumed on a family farm as part of a program to control the volume and price of wheat moving

in interstate commerce. The Court sustained that exercise of the commerce power even though the wheat at issue was not "sold or intended to be sold," 317 U.S. 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.

The district court's analysis disregards the role of insurance as the principal means of payment for services in the health care services market. Buying insurance is one method of dealing with the cost of potential medical expenses, in preference to other options. Porat et al., *Market Insurance versus Self Insurance*, 58 J. Risk & Ins. 657, 668 (1991). Those who resort to those other options may "use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services." Ruger, *supra*, 100 Q.J. Med. at 55. Implicitly or otherwise, these actions commonly reflect economic assessments of the relevant advantages of obtaining insurance versus other means of attempting to pay for health care services, although those assessments often ignore or underestimate the risks. Pauly, *Risks and Benefits in Health Care: The View From Economics*, 26 Health Affairs 653, 658 (2007).[6]

[6] Whereas 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," with regard to medical expenses it has also "become common to rely on

"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*, 2010 WL 4860299, *15. Some individuals may prefer to pay for health care services out of pocket rather than through insurance. But that type of economic preference is plainly subject to regulation under the Commerce Clause. "As Congress found, the total incidence of these economic decisions has a substantial impact on the national market for health care by collectively shifting billions of dollars on to other market participants and driving up the prices of insurance policies." *Ibid.*; *Mead*, 2011 WL 611139, *20. Moreover, substantial evidence supports Congress's judgment that its regulation of medical underwriting would be undermined without a requirement that consumers maintain minimum insurance coverage.

The district court was thus quite wrong to declare that the rationales for upholding the minimum coverage provision "could apply to transportation, housing, or nutritional decisions." JA 1097. In contrast to other markets, the timing and extent

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insurance to pay for regular medical examinations and often for prescriptions." Milton Friedman, How To Cure Health Care, The Public Interest, Winter 2001, at 10; *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.").

of medical needs are unpredictable and their costs can easily dwarf consumers' other expenses and exceed their ability to pay. That is a principal reason that payments for medical services, unlike payments in other markets, are generally made through insurance. Moreover, unlike in other markets, if consumers of health care services fail to maintain adequate coverage, they nevertheless obtain expensive care in times of need for which other consumers must ultimately pay.

The Affordable Care Act prevents the substantial cost-shifting in the interstate health care services market that results from the practice of consuming health care without insurance. At the same time, the Act makes everyone insurable under a system of guaranteed issue and community rating, and thus provides protection against the risk of being left destitute by catastrophic medical expenses. 42 U.S.C.A. § 18091(a)(2)(G) (62% of personal bankruptcies are caused in part by medical expenses). Even apart from the other rational bases for Congress's choice of means, "[t]his benefit makes imposing the minimum coverage provision appropriate." *Thomas More*, 720 F. Supp. 2d at 894.

b. The district court thus erred in analyzing the minimum coverage provision through the lens of "inactivity," rather than by reference to "broad principles of economic practicality," *Lopez*, 514 U.S. at 571 (Kennedy, J., concurring). The Supreme Court has long held that "questions of the power of Congress are not to be

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

Thus, federal statutes address practical economic circumstances, and need not be triggered by "some type of self-initiated action." JA 1098. For example, under the Superfund Act, a property owner may be subject to a remediation order whether or not he has engaged in interstate commerce and without any showing that he acted to cause the contamination. 42 U.S.C. § 9607(a). Even a former property owner may be subject to a remediation order if he permitted hazardous waste to leak on his property "without any active human participation." *Nurad, Inc. v. William E. Hooper & Sons Co.*, 966 F.2d 837, 845 (4th Cir. 1992). The property owner's characterization of his own behavior as "passive" is irrelevant; otherwise, "an owner could insulate himself

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

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

a. The district court cited no authority for its holding, and no support can be found in *Lopez* and *Morrison*, the only modern cases to invalidate federal statutes as beyond the commerce power. Both statutes were stand-alone measures that involved no economic regulation. In *Lopez*, the Supreme Court struck down a ban on possession of handguns in school zones because the ban was related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might ultimately undermine economic productivity. Similarly, in *Morrison*, the

Court invalidated a tort cause of action established by the Violence Against Women Act, explaining that it would require a chain of speculative assumptions to connect gender-motivated violence with interstate commerce. Neither of these measures played any role in broader regulation of economic activity, and the "noneconomic, criminal nature of the conduct at issue was central" to the decisions. *Morrison*, 529 U.S. at 610; *see also Sabri v. United States*, 541 U.S. 600, 607 (2004).

The minimum coverage provision, in contrast, concerns intrinsically economic activity by requiring health insurance as the means of payment for services in the interstate health care market. It is part of a broad economic regulation of health care financing in the massive interstate health care market, and it is essential to the Act's regulation of underwriting practices in the insurance industry. It is difficult to conceive of legislation more clearly economic than the Act's regulation of the means of payment for health care services and the requirements placed on insurers, employers, and individuals made insurable by the Act. Far from the chain of attenuated reasoning required in *Lopez* and *Morrison* to identify a substantial effect on interstate commerce, the link to interstate commerce in this case is direct and compelling.

b. *Lopez* and *Morrison* sought to avoid a view of economic causation so broad that it would "obliterate the distinction between what is national and what is local in

the activities of commerce." *Morrison*, 529 U.S. at 608 (quoting *Lopez*, 514 U.S. at 557). The district court did not suggest that the Affordable Care Act intrudes into an area of regulation that is reserved to the states, or that the problems besetting our health care system can be solved comprehensively on a state-driven basis. "Affordable health care is a national problem that demands a national solution." Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 New England J. Med. e29(1), e29(3) (2010).

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

These phenomena have been amplified by modern transportation, which, the Supreme Court acknowledged, expanded the contours of Congress's commerce power. *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 251 (1964). Given the ease of travel, illnesses can spread rapidly and individuals can suddenly need health care

services far from home.[7] In some cases, consumers travel to obtain services not readily available in their own state. For example, this Court noted in *Hoffman*, 126 F.3d at 587, "that many women travel across state lines to obtain reproductive health care, that facilities providing these services retain staff in an interstate employment market and utilize supplies obtained through interstate commerce." Similarly, residents of southwestern Pennsylvania make more than 1500 emergency room visits to a teaching hospital in West Virginia. *See* Amicus Br. of the Governors of Washington, Colorado, Michigan, and Pennsylvania, *State of Florida v. HHS*, No. 3:10-cv-91 (N.D. Fla.), at 9 (noting also that a medical center in Seattle is the only Level 1 trauma center for the four-state region of Washington, Alaska, Montana, and Idaho).

Prior to the Affordable Care Act, this mobility created potential disincentives for individual states to adopt comprehensive reforms of their health care and health insurance markets.[8] A state might reasonably have resisted providing more generous benefits or broader coverage than its neighboring states out of concern that it would

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

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

become "a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose." *Helvering v. Davis*, 301 U.S. 619, 644 (1937). In addition, a state considering reform of restrictive insurance practices might have worried that insurers — mostly regional or national companies, 42 U.S.C.A. § 18091(a)(2)(B) — would respond to such regulations "simply by pulling up stakes" (particularly if the state's reforms lacked a minimum coverage provision). Rosenbaum, *supra*, at e29(3); *see also* pp. 38-39, *supra*. This circumstance contrasts sharply with the situations in *Lopez* and *Morrison*, which the Court found involved traditional subjects of state criminal law enforcement focused on local actors.

Moreover, regulation of health care and health insurance implicates mobility between jobs and among states, considerations absent in *Lopez* and *Morrison*. Health insurance is often an element of employees' compensation. If employees put their insurance at risk if they change jobs, they may be "reluctant to switch jobs in the first place (a phenomenon known as 'job lock')." CBO, Key Issues at 8. As Congress understood, the prospect of losing employee health insurance may obstruct interstate mobility, which the Constitution generally, and the commerce power specifically, were designed to prevent. *Heart of Atlanta*, 379 U.S. at 253 (noting that "uncertainty stemming from racial discrimination had the effect of discouraging travel").

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

This Court has repeatedly held that Congress can regulate matters that relate to the cross-border challenges associated with health care and other markets. For example, because "[r]eports concerning [physician] peer review proceedings are routinely distributed across state lines and affect doctors' employment opportunities throughout the Nation," there is "no doubt concerning the power of Congress to regulate a peer review process." *Freilich*, 313 F.3d at 213. Similarly, in upholding the Freedom of Access to Clinic Entrances Act, this Court reasoned that, although the obstruction of clinic entrances "is not itself commercial or economic in nature, it is closely connected with, and has a direct and profound effect on, the interstate commercial market in reproductive health care services." *Hoffman*, 126 F.3d at 588.

A similar understanding of Commerce Clause principles underlies *Gibbs v. Babbitt*, 214 F.3d 483 (4th Cir. 2000), in which this Court upheld a statute that barred

the taking of a red wolf on private land, noting that "[f]armers and ranchers take wolves mainly because they are concerned that the animals pose a risk to commercially valuable livestock and crops," and that red wolves generated tourism and scientific research as well as trade. *Id*. at 492. The Court observed that, "[w]hile a beleaguered species may not presently have the economic impact of a large commercial enterprise, its eradication nonetheless would have a substantial effect on interstate commerce." *Id*. at 493. *See also Gould*, 568 F.3d at 475 ("A complex regulatory program ... can survive a Commerce Clause challenge without a showing that every single facet of the program is independently and directly related to a valid congressional goal. It is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole satisfies this test.") (quoting *Hodel v. Indiana*, 452 U.S. 314, 329 n. 17 (1981)).

At the end of the day, evaluation of whether an action by Congress is necessary and proper calls for a deferential examination of the legislation in question, its factual context, and Congress's reasons for acting. The analysis cannot be driven by hypothetical statutes that no legislature would ever adopt. Congress's commerce power to enact minimum wage legislation, *Darby*, 312 U.S. 100, is not defeated because, hypothetically, Congress could use that power to set a minimum wage of $5,000 per hour. As Chief Justice Marshall explained, "[t]he wisdom and the

discretion of Congress, their identity with the people, and the influence which their constituents possess at elections, in this, as in many other instances, as that, for example, of declaring war, the sole restraints on which they have relied, to secure them from its abuse. They are the restraints on which the people must often rely solely, in all representative governments." *Gibbons v. Ogden*, 22 U.S. 1, 197 (1824). Justice Story likewise recognized that it is manifestly incorrect to suggest that, "because Congress had not hitherto used a particular means to execute any ... given power, therefore it could not now do it." 3 Joseph Story, *Commentaries on the Constitution of the United States* § 1132, at 39 (1833). Such a rule would mean that, "if [C]ongress had never provided a ship for the navy, except by purchase, [it] could not now authorize ships to be built for a navy"; that, "[i]f [Congress] had not laid a tax on certain goods, it could not now be done"; and that, "[i]f [Congress] had never erected a custom-house, or a court-house, [Congress] could not now do it." *Ibid.* That "mode of reasoning would be deemed by all persons wholly indefensible." *Ibid.*

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

III. The Minimum Coverage Provision Is Also Independently Authorized by Congress's Taxing Power.

The minimum coverage provision is also independently authorized by Congress's power to "lay and collect taxes." U.S. Const. art. I,§ 8, cl. 1. The taxing power is "comprehensive," *Steward Mach. Co.*, 301 U.S. at 581-82, and "plenary," *Murphy v. IRS*, 493 F.3d 170, 182-83 (D.C. Cir. 2007), and it is established 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*, 312 U.S. at 363; *see also United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by operation of Internal Revenue Code had "essential character as taxes" despite statutory label as "penalties").

The minimum coverage provision amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of insurance

shall pay a monthly tax penalty for so long as he fails to do so. 26 U.S.C.A. § 5000A. The practical operation of the provision is as a tax. Individuals who are not required to file income tax returns for a given year are not required to pay the penalty. *Id.* § 5000A(e)(2). The amount of any penalty is calculated in part by reference to household income for federal income tax purposes; it is reported on the individual's federal income tax return for the taxable year and is assessed and collected in the same manner as certain other federal tax penalties. *Id.* § 5000A(b)(2), (c)(1), (2), (g). The taxpayer's responsibility for family members depends on their status as dependents under the Internal Revenue Code. *Id.* § 5000A(a), (b)(3). Taxpayers filing a joint tax return are jointly liable for the penalty. *Id*. § 5000A(b)(3)(B). And the Secretary of the Treasury is empowered to enforce the penalty provision. *Id.* § 5000A(g). By creating a liability that must be reported on the taxpayer's federal income tax return and granting enforcement authority to the Secretary of the Treasury, the provision operates as a taxing measure. *In re Leckie Smokeless Coal Co*., 99 F.3d 573, 583 (4th Cir. 1996).

There is no dispute that this provision will be "productive of some revenue." *Sonzinsky*, 300 U.S. at 514. The CBO estimated that, by 2019, the minimum coverage provision will yield $4 billion annually. Letter from Douglas W. Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, U.S. House of Representatives, table 4 (Mar. 20,

2010); *see also* Pub. L. No. 111-148, § 1563(a)(1), 124 Stat. 119, 270 (adopting CBO finding that the Act "will reduce the Federal deficit").[9]

Contrary to the district court's understanding, Congress was not required to invoke its taxing power explicitly or to label the payment a "tax." *See Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948) ("constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise"); *Leckie*, 99 F.3d at 576, 586 ("premium" on coal operators is an exercise of taxing power despite Commerce Clause findings). The Constitution itself uses four different terms to refer to the concept of taxation: tax, impost, duties, and excises. U.S. Const. art I, § 8, cl. 1. Congress likewise used the terms "tax" and "assessable payment" interchangeably in the Affordable Care Act's employer responsibility provision. 26 U.S.C.A. § 4980H(b)(1), (2). In drafting the Act, Congress repeatedly referred to the penalties as taxes, and during legislative debates congressional leaders explicitly defended the provisions as an exercise of the taxing power. *See* 156 Cong. Rec. H1854, H1882 (Mar. 21, 2010) (Rep. Miller); *id.* at H1824, H1826 (Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (Dec. 22, 2009) (Sen. Leahy); *id.*

[9] More recent CBO projections indicate that by 2021, the minimum coverage provision will yield $5 billion annually. Letter from Elmendorf to Boehner, *supra*, table 3.

at S13,558, S13,581-82 (Dec. 20, 2009) (Sen. Baucus); *see also* H.R. Rep. No. 111-443(I), at 265 (2010).

Although the taxing power may not be used to impose "punishment for an unlawful act," *United States v. LaFranca*, 282 U.S. 568, 572 (1931), the minimum coverage provision does not impose "punishment." It does not apply retrospectively; instead, it imposes a month-to-month penalty for a failure to maintain adequate coverage, with liability ceasing when adequate coverage is obtained. 26 U.S.C.A. § 5000A(a)-(c). The tax cannot exceed the cost of qualifying insurance, *id.* § 5000A(c), and the provision has a "hardship" exemption, *id*. § 5000A(e)(5). The Act bars criminal prosecution for failure to obtain coverage, *id.* § 5000A(g)(2)(A).

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

CONCLUSION

The judgment of the district court should be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that, according to the word count provided in Corel WordPerfect 12, the foregoing brief contains 13941 words. The text of the brief is composed in 14-point Times New Roman typeface.

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

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CERTIFICATE OF SERVICE

I hereby certify that on February 28, 2011, I filed and served the foregoing Opening Brief for Appellant with the Clerk of the Court by causing a copy to be electronically filed and served via the appellate CM/ECF system. I also hereby certify that I have caused copies to be delivered to the Court by Federal Express, and caused copies to be served upon the following counsel by Federal Express:

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