UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO

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

MEMORANDUM IN OPPOSITION TO
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), to establish a comprehensive regulation of insurance coverage in the national health care market. Plaintiffs here assert that one section of the Act, the minimum coverage provision codified at 26 U.S.C. § 5000A, was enacted in excess of the enumerated powers accorded to Congress under Article I. Plaintiffs' claim fails, as the provision falls well within the Congressional commerce power, as well as the Congressional taxing power. Defendants' motion for summary judgment should accordingly be granted, and plaintiffs' motion should be denied. Defendants respectfully request the opportunity to present argument in support of their motion for summary judgment.

As is well known, Congress has the power to enact regulations that address matters with substantial effects on interstate commerce. Congress not only had a rational basis, but an ample legislative record, to conclude that the use of health care services by the uninsured population imposes substantial effects on interstate commerce. Participation in the national health care market is nearly universal, among the insured and the uninsured alike. When persons without insurance coverage use health care services, they cannot and do not pay the full cost of those services. The cost of that uncompensated care—at least $43 billion in 2008 alone—is instead paid by providers, by governments, by insurers, and, ultimately by the insured population in the form of higher premiums. Congress plainly has the authority under its commerce power to address these burdens imposed on the national health care market.

Plaintiffs attempt to avoid this result by characterizing their behavior as "inactivity." But plaintiffs, by their own admission, are active participants in the health care market; similarly, the overwhelming majority of the uninsured population actively uses health care

services—that is, they actively engage in the economic transaction of purchasing medical services, even if others pay the bill for those purchases. Plaintiffs' "inactivity" theory depends on their insistence that Congress was required to define the relevant market in the way that they prefer, to include only health insurance, and that Congress was required to ignore the larger market for health care services—a market in which plaintiffs admittedly are active participants. No rule of law requires Congress to define the subject of its regulation in this artificial manner; Congress instead may address economic reality, in which insurance coverage is not a stand-alone product, but is the principal means of payment in the market for health care services.

Plaintiffs further argue that, even if Congress may address cost-shifting generally, that regulation may not extend to them, because they do not expect to shift the costs of their own health care expenditures. But even if plaintiffs do not shift the costs of their health care, millions of other people who are not insured will. Congress is entitled to focus on that aggregate effect. Moreover, plaintiffs ignore the reality of the health care marketplace. Nobody can know with certainty the timing or extent of their health care needs, and even healthy individuals may find themselves suddenly in need of expensive care. Because no person—not even these plaintiffs—can know for sure that he will not find himself in that situation, it is not surprising that the uninsured population pays for less than half of the cost of their health care expenses, or that this result holds true for those with higher incomes and for those with lower incomes alike.

The minimum coverage provision also falls well within Congress's commerce power because it forms an integral part of the Act's regulatory scheme. Among other reforms, the Act regulates the terms and conditions of health insurance policies offered in interstate

commerce. It has long been established that Congress has such power. In particular, the Act requires "guaranteed issue," that is, it requires insurers to guarantee coverage to all applicants without regard to their medical condition or history, and "community rating," that is, it bars insurers from discriminating in the pricing of premiums on the basis of those factors. Congress found these reforms to be necessary because millions of Americans, even those with relatively minor pre-existing conditions, have found themselves unable to purchase individual coverage due to industry practices that screen or price these persons out. And Congress found it essential to couple these reforms with the minimum coverage provision, as otherwise its reforms would set in motion a spiral of increasing premiums and decreased coverage, because individuals could wait to purchase insurance until they were ill or injured, knowing that insurers would be required to cover them at no greater cost. This link also establishes the constitutionality of 26 U.S.C. § 5000A, as Congress has the authority to adopt means that it finds necessary to implement its enumerated powers.

Plaintiffs do not dispute this link, but they argue that Section 5000A must nevertheless be struck down, as otherwise Congress would have an incentive to "legislate broadly," or to adopt measures with known "negative consequences" so as to justify additional action to rectify those consequences. This is not the law; Congress has always had the power to adopt integrated regulatory schemes, and it has the power to consider whether the pursuit of one policy might have side effects that require adjustment through a second policy. Plaintiffs' claim, ultimately, is that it was not worth it, as a policy matter, to protect the millions of Americans with pre-existing conditions if those reforms required the minimum coverage provision as well. But that is a policy question, and it is reserved for Congress, not for plaintiffs or for this Court.

Plaintiffs further assert that Congress has claimed a limitless "police power" which must be invalidated to avoid the result that Congress can regulate anything. Congress, of course, regulates only pursuant to its enumerated powers, but there is no need to speculate here as to the limits of those enumerated powers, or which side of the dividing line the minimum coverage provision falls on. Congress may not regulate a wholly non-economic subject matter, where the link of that subject matter to interstate commerce depends on an attenuated chain of inferences, and where that subject matter is not an integral part of a larger regulation of commerce. But no chain of inferences is required here to link Section 5000A to interstate commerce; that provision directly regulates an economic subject, the means of payments for the commercial transaction of purchasing health care services. And, as noted, the provision is an integral part of the Act's larger regulation of the interstate market.

The minimum coverage provision is also well justified under the Article I taxing power. Section 5000A has the practical operation of a tax; it applies only to those who are required to file federal income tax returns, any penalty is reported on that return, and it is calculated in accordance with household income, as that term is defined for federal tax purposes. The provision also indisputably raises revenue for the general treasury. It is, without question, an exercise of the taxing power in addition to the commerce power.

As the minimum coverage provision falls well within Congress's Article I powers, there is no need to consider plaintiffs' claim that the entirety of the Affordable Care Act stands or falls with that provision. Plaintiffs, in any event, lack standing to address the severability question, as they identify no provision of the Act apart from Section 5000A that burdens them in any way. If the issue were to be reached, however, the vast majority of the Act would remain legally operative in the absence of 26 U.S.C. § 5000A, and it is not

evident that Congress intended the entirety of its statute to stand or fall with that provision. Apart from the Act's "guaranteed issue" and "community rating" reforms, which do depend on the minimum coverage provision (thereby, as discussed, proving that provision's constitutionality), this Court should not take the extraordinary step of invalidating the entire statute based on plaintiffs' speculation as to Congress's intent.

In sum, there is vigorous public debate regarding Congress's policy choices when it enacted the Affordable Care Act. But the Constitution assigns those policy choices to the legislature, not to the courts. In enacting 26 U.S.C. § 5000A, Congress sought to address the significant issue of cost-shifting within the national health care market, and to ensure the effectiveness of the protections that it created for the millions of Americans with pre-existing conditions. Article I of the Constitution affords Congress the power to do so.

ARGUMENT

I. CONGRESS ACTED WELL WITHIN ITS CONSTITUTIONAL POWERS IN ADOPTING THE MINIMUM COVERAGE PROVISION

Plaintiffs claim that Congress exceeded its Article I powers in enacting the minimum coverage provision, 26 U.S.C. § 5000A. To prevail on this claim, they must make a "'plain showing that Congress has exceeded its constitutional bounds.'" *United States v. Ostrander*, 411 F.3d 684, 694 (6th Cir. 2005) (quoting *United States v. Morrison*, 529 U.S. 598, 607 (2000)). They cannot meet this heavy burden, as the provision is well within Congressional authority. First, Congress acted well within its authority to adopt measures that are necessary and proper to the regulation of interstate commerce when it enacted 26 U.S.C. § 5000A. The minimum coverage provision addresses activity with substantial effects on interstate commerce, namely, the use of health care services by the uninsured population—a practice

that shifts at least $43 billion in costs annually to other participants in the national health care market. Further, Congress reasonably found the provision to be necessary to ensure the effectiveness of its larger regulation of the interstate insurance industry. It is well established that the commerce power permits Congress to enact regulations that it determines are integral to a larger regulation of interstate markets. Second, the minimum coverage provision raises revenue and operates as a tax, and is a valid exercise of Congress's independent taxing authority under the General Welfare Clause.

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

1. The Use of Health Care Services by the Uninsured Population Imposes Significant Burdens on Other Participants in the National Health Care Market

The minimum coverage provision falls well within Congress's commerce power, as it regulates conduct with substantial effects on interstate commerce. The Commerce Clause affords Congress broad authority to "regulate activities that substantially affect interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 16-17 (2005). This includes power not only to regulate markets directly, but also to regulate even non-commercial matters that have clear and direct economic effects on interstate commerce. *See United States v. Bowers*, 594 F.3d 522, 527-28 (6th Cir. 2010). The determinative question is whether Congress could rationally find that the conduct it seeks to regulate has, in the aggregate, a substantial effect on interstate commerce. *See Raich*, 545 U.S. at 22; *see also Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942).

These holdings settle the question of the minimum coverage provision's constitutionality. Although the "unique nature of the market for health care and the breadth

of the Act present a novel set of *facts* for consideration," the law governing Congressional authority is not at all novel; rather, "the *well-settled principles* expounded in *Raich* and *Wickard* control the disposition of this claim." *Liberty Univ. v. Geithner*, --- F. Supp. 2d ---, 2010 WL 4860299, at *14 (W.D. Va. 2010) (emphasis added).[1]

Defendants have explained many of the ways in which economic decisions regarding how to pay for health care services substantially affect interstate commerce. *See* Defs.' Mem. in Supp. of Mot. for Summ. J. at 21-24 (ECF No. 70-1). Participation in the national health care market is nearly universal. This is no less true of the uninsured population, which participates in the health care market by receiving medical services. Nationwide, the uninsured consume over $100 billion of health care services annually. FAMILIES USA, HIDDEN HEALTH TAX: AMERICANS PAY A PREMIUM 2 (2009) ($116 billion in 2008) (Ex. 24 to Defendants' Motion for Summary Judgment). The average person without health insurance coverage for a full year, however, pays for only about one-third of the cost of his medical expenditures. Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs 2008*, 27 HEALTH AFFAIRS w399, w401 (2008) (Defs.' Ex. 28). The remaining costs are shifted on to other participants in the health care market; that cost shifting amounted to at least $43 billion in 2008. 42 U.S.C. § 18091(a)(2)(F). These costs are paid in part by public funds; the remainder falls in the first instance on health care providers, who in turn "pass on the cost to private insurers, which pass on the cost to families." *Id.*

[1] The contrary holding of the district court in *Florida v. U.S. Dep't of Health & Human Servs.*, 2011 WL 285683 (N.D. Fla. 2011), cannot be reconciled with the Supreme Court's decisions in *Raich* and *Wickard*. Its decision rests instead on its conclusions that *Raich* was both "surprising[]" and wrongly decided, *id.* at *19-20, and that the holding of *Wickard* (which was specifically reaffirmed in *Raich*) was "ridiculous," *id.* at *24 n.20.

The substantial effects that the uninsured population imposes on the rest of the health care market are thus well documented. These effects resolve the matter, because Congress may regulate activity that, in the aggregate, imposes such substantial burdens on an interstate market. *See, e.g.*, *United States v. Faasse*, 265 F.3d 475, 490-91 (6th Cir. 2001) (en banc).[2] Plaintiffs attempt to dispute Congress's findings on this score, but they can do so only by pretending that the factual record before Congress did not exist, and by ignoring that this Court reviews that record only for a rational basis.[3] Plaintiffs, inexplicably, contend that the minimum coverage provision fails the "substantial effects" test because the focus must be on "whether the activity has a substantial effect on the market *to be* regulated *before* the law in question is effectuated." Pls.' Mem. in Supp of Mot. for Summ. J. at 11 (ECF No. 69-1) (emphasis in original). This is a *non sequitur*. The uninsured already shift their costs on to unwilling recipients. The economic effects of this practice are not hypothetical, but have been proven to exist in the present day. Congress is not powerless to address this economic practice.

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[2] *Faasse* upheld the Congressional power to regulate the failure to make child support payments. Plaintiffs attempt to reconcile this case with their "inactivity" theory by asserting that the defendant's failure to make a payment was "an act." Pls.' Mem. at 38. The distinction that plaintiffs wish to draw between an "active" failure to pay in that case and the supposedly "passive" failure by the uninsured population to make full payment for their health care expenditures is not readily apparent.

[3] Plaintiffs also ignore that this Court reviews Congress's exercise of its Article I powers only for a rational basis, and thus attempt to dispute the wisdom of Congress's policy judgments. In doing so, they misread their cited material. For example, they believe that Medicare's actuary found that the ACA will increase the rate of growth in national health care expenditures. He instead found that the Act, as enacted, would result in "noticeable downward effects" in those expenditures. Pls.' Ex. 4, at 17-18. And contrary to plaintiffs' citation to newspaper articles claiming low rates of insurance after Massachusetts enacted reforms similar to the ACA, the actual record shows that 98.1% of residents of that state are now insured, Mass. Div. of Health Care Fin. & Policy, *Health Insurance Coverage in Massachusetts*, at 1 (Dec. 2010), with premiums dropping substantially in that state, *see* Defs.' Ex. 37.

Plaintiffs' reasoning is echoed in the recent decision of the court in *Florida v. U.S. Dep't of Health & Human Servs*., --- F. Supp. 2d ---, 2011 WL 285683 (N.D. Fla. 2011), which without explanation concluded that the uninsured population has an effect on commerce amounting to "zero." *Id.* at *26. But the uninsured do use health care services, and they shift not "zero," but at least $43 billion annually, in the cost of their medical care to other market participants. Congress rationally found this to be the case, 42 U.S.C. § 18091(a)(2)(F), and neither plaintiffs nor the court in *Florida* can cite to any evidence that could even cast doubt on this finding, let alone that would show the finding to be lacking even a rational basis. The "market reality" instead is that "[h]ow participants in the health care services market pay for such services has a documented impact on interstate commerce"; the law is clear that Congress may address those documented impacts under its commerce power, whether or not plaintiffs might speculate without any basis that those effects are actually zero. *See Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010);[4] *see also Liberty Univ.*, 2010 WL 4860299, at *15.

Building on the misconception that the uninsured population imposes "zero" in costs on the rest of the health care market, the court in *Florida* surmised that Section 5000A is unconstitutional because it targets "inactivity" by applying to "everyone *in the present*," rather than applying to individuals in the future when they seek care. *Florida*, 2011 WL 285683, at *26 (emphasis in original). In that court's view, Congress could impose an insurance requirement only at the point in time that uninsured persons seek medical care,

[4] The plaintiffs' appeal in *Thomas More* is pending before the Sixth Circuit, and the parties have completed briefing. The court has granted the appellants' unopposed motion to expedite oral argument in that appeal, and will hear argument during the court's session of May 30 through June 10, 2011.

even though there is no dispute that the use of health care services is essentially universal. *Id.*[5] The implications of this point of view are far-reaching. No humane society could impose barriers, like an insurance requirement, at the door of the hospital. The health care market is unique, in part, because there is a widespread expectation that services in that market will be provided as a matter of right, without first inquiring into the patient's ability to pay. This expectation is reflected in the Emergency Medical Treatment and Active Labor Act, 42 U.S.C § 1395dd, which guarantees access to emergency room services in hospitals that accept Medicare, even for those who cannot pay. The alternative form of regulation that the court in *Florida* proposed cannot be squared with this national commitment to provide a minimum level of care to all. Moreover, that court's proposed alternative would practically fail, as no health insurance market could survive "if people could buy their insurance on the way to the hospital." *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Fin.*, 110th Cong. 52 (2008) (statement of Prof. Hall) (Defs.' Ex. 19.) The problem of the cost-shifting of uncompensated care can be addressed only through ensuring that people have insurance in advance of their trip to the hospital. Congress, at least, could rationally tailor its policy in this manner. The Constitution does not dictate the policy that the court in *Florida* suggested.

[5] The activity regulated under Section 5000A and under *Florida*'s proposed alternative is the same: the use of health care services in the absence of insurance. That court differed from Congress only in the choice of means to address that underlying problem. But once an activity substantially affects interstate commerce, bringing it within Congress's commerce power to address, that choice of means is "'for congressional determination alone.'" *United States v. Comstock*, 130 S. Ct. 1949, 1957 (2010) (quoting *Burroughs v. United States*, 290 U.S. 534, 547-48 (1934)).

2. Plaintiffs May Not Avoid Congressional Regulation by Characterizing Themselves as "Inactive"

As described above, the minimum coverage provision falls well within the commerce power, given the substantial effects that the uninsured population imposes on the rest of the interstate health care market through the use of health care services for which others must pay. Plaintiffs attempt to avoid this result by asserting that they, and other uninsured persons, are engaged only in "inactivity," Pls.' Mem. at 1, or that "the Plaintiffs are doing nothing," *id.* at 38. This is plainly false. Plaintiffs themselves concede that they actively participate in the health care market. Thompson Aff. ¶ 9; Grapek Aff. ¶ 6. And, as mentioned above, the empirical evidence shows that the uninsured population, as a class, regularly uses health care services, and in so doing shifts billions of dollars each year in the costs of their care to other market participants. These costs do not appear out of thin air. They instead arise from individual conduct by the uninsured that in the aggregate has enormous economic consequences—the economic activity of obtaining health care services for which the uninsured do not, and cannot, fully pay. The conduct of the uninsured population—their active use of the health care system, their economic decisions as to how to finance that use, their migration in and out of insurance coverage, and their shifting of costs on to the rest of the system when they cannot pay—plainly is economic activity. Indeed, the uninsured are even more directly engaged in economic activity than the plaintiffs in *Raich*, who consumed only home-grown marijuana and had no intent to enter the marijuana market.

Plaintiffs' contrary argument turns on their attempt to focus the Court's attention only on their lack of participation in the "market for health insurance." *E.g.*, Pls.' Mem. at 11. Plaintiffs repeatedly claim to be inactive in the submarket for health insurance, *see id.* at 4, 5,

11, 22, 25, 26, 32, but they studiously avoid discussing their activity in the overall market for *health care*. There is no requirement that Congress focus its attention on a market as the plaintiffs define it. Instead, Congress is entitled to take the broader view, and to recognize the fundamental nature of health insurance, which is not a stand-alone good but instead serves as the principal means of payment for health care services in the United States. Because participation in the health care market is universal, but no person can accurately predict the timing or the extent of their need to make health care expenditures, the decision whether to carry insurance or to attempt to pay for one's inevitable use of health care services through other means is "plainly economic." *Thomas More*, 720 F. Supp. 2d at 893. Plaintiffs may prefer to attempt to finance their health care expenditures out-of-pocket, but that preference "is much like the preference of the plaintiff farmer in *Wickard* for fulfilling his demand for wheat by growing his own rather than by purchasing it." *Liberty Univ.*, 2010 WL 4860299, at *15.

Plaintiffs' participation, or lack thereof, in health insurance coverage thus cannot be divorced from their undoubted participation in the health care market. An interstate trucker without insurance, to take only one example, may be "active" in the interstate trucking market, but "inactive" in the interstate trucking *insurance* submarket, under plaintiffs' reasoning. Yet it is entirely uncontroversial that Congress can require these persons to carry insurance, in order to prevent unwarranted cost-shifting. 49 U.S.C. § 13906(a)(1). The same analysis holds here. Whether or not the uninsured population could plausibly be described as "inactive" with respect to insurance coverage (and even this is doubtful, as the majority of those without coverage at any given point in time in fact are migrating in and out of coverage, *see* CONGRESSIONAL BUDGET OFFICE ("CBO"), HOW MANY PEOPLE LACK

HEALTH INSURANCE AND FOR HOW LONG? at 4, 9 (2003) (Defs.' Ex. 14)), they are indisputably "active" with respect to the overall market for health care services, of which insurance coverage plays a part.

3. Plaintiffs May Not Avoid Congressional Regulation by Redefining the Class that Congress Sought to Regulate

Plaintiffs also contend that the minimum coverage provision cannot constitutionally be applied to them, or to other persons with incomes of more than 400% of the federal poverty level, because "they presently pay out-of-pocket for health care and will pay out of pocket for all future health care costs, including catastrophic ones." Pls.' Mem. at 39.[6] They argue that Congress did not make a specific finding that uninsured persons with higher incomes shift their health care costs on to the rest of the system. *Id.* But the courts "have never required Congress to make particularized findings in order to legislate" under its Article I powers, let alone findings at the level of specificity that plaintiffs here demand. *Raich*, 545 U.S. at 21; *see also id.* at 21 n.32. Instead, where "Congress decides that the 'total incidence' of a practice" — here, the practice of consuming health care without insurance — "poses a threat to a national market, it may regulate the entire class." *Id.* at 17 (quoting *Perez v. United States*, 402 U.S. 146, 154-155 (1971)).

[6] In prior briefing, plaintiffs attempted to support this implausible assertion by claiming that the uninsured frequently "contract with private hospitals to pay for catastrophic care out of pocket on agreeable terms." Pls.' Mem. in Opp. to Mot. to Dismiss at 24. It is not clear how plaintiffs envision that an uninsured patient could negotiate rates at the emergency room door before being admitted for surgery. This negotiation is in any event forbidden under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, which requires hospitals that participate in Medicare and offer emergency services to stabilize any patient who arrives with an emergency condition, regardless of ability to pay. Plaintiffs' assertion that such negotiations are both possible and common turns on their misreading of their cited material; the term "fee-for-service" refers to a method of payment by *insurers* to medical providers. CBO, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 102 (Dec. 2008) (Defs.' Ex. 9.)

In any event, plaintiffs' premise—that only the lower-income portion of the uninsured population shifts their costs—is wrong. Even higher-income persons without insurance pay on average less than half of the full cost of their medical care, and they thereby obligate other market participants to pay for the care that they receive. *See* Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. HEALTH ECON. 225, 230 (2005) (Defs.' Ex. 11.) This is not surprising. Cancer, to take only one example, will not strike a relatively affluent person with any more warning than it will a poor person. Without insurance, few people could entirely absorb, for example, the $150,000 or more it costs for drug treatment alone for a common form of cancer. *See* Neal J. Meropol *et al*., *Cost of Cancer Care: Issues and Implications*, 25 J. CLIN. ONCOL. 180, 182 (2007) (Defs.' Ex. 8).

Congress, then, had far more than a rational basis not to excise plaintiffs out of the class that it regulated. The uninsured, including those with higher incomes, shift the costs of their medical care on to other market participants. And persons with both high and low incomes would have an incentive to game the system and to undermine the Act's "guaranteed-issue" and "community-rating" reforms in the absence of the minimum coverage provision. But, as noted, even apart from these obvious bases for Congress's policy judgment, Congress is not required to individualize a regulation of nationwide applicability. Because the "'general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence.'" *Raich*, 545 U.S. at 17 (quoting *United States v. Lopez*, 514 U.S. 549, 558 (1995)); *see also Bowers*, 594 F.3d at 524.

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

1. The Minimum Coverage Provision Is a Rational Means to Implement Congressional Authority to Regulate the Terms and Conditions of Insurance Policies Sold in Interstate Commerce

Congress enacted the ACA to address a national crisis—an interstate health care market constituting more than one-sixth of the American economy, in which tens of millions of Americans went without insurance coverage and in which the costs of treatment spiraled out of control. As part of a comprehensive reform effort seeking, among other things, to reduce the ranks of the uninsured, the ACA regulates quintessentially economic decisions regarding the means of payment for health care services. In particular, the ACA reforms insurance industry practices; it prevents insurers from denying or revoking coverage for those with pre-existing conditions, and it prevents insurers from charging discriminatory rates because of those conditions. 42 U.S.C. §§ 300gg, 300gg-1(a), 300gg-3(a). These "guaranteed issue" and "community rating" reforms directly regulate the interstate health insurance market, and without question fall within Congress's authority to regulate that market under its commerce power. *See United States v. S-E Underwriters Ass'n*, 322 U.S. 533, 552-53 (1944). These are reasonable measures to protect millions of Americans from practices that would prevent them from obtaining or retaining insurance in the event of unexpected, and possibly catastrophic, illness or injury.

Congress also found the minimum coverage provision to be necessary to effectuate this regulation of the insurance industry. If the bar on denying coverage or charging more to people because of pre-existing conditions were not coupled with a minimum coverage provision, individuals would have powerful incentives to wait until they fall ill before they

buy health insurance. 42 U.S.C. § 18091(a)(2)(I). Without that provision, the insurance industry reforms would create a spiral of rising premiums and a declining number of individuals covered. *See Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. 13 (2009) (statement of Uwe Reinhardt, Ph.D.) (Defs.' Ex. 20). The minimum coverage provision thus is "'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated,'" and is well within the commerce power. *Raich*, 545 U.S. at 24-25 (quoting *Lopez*, 514 U.S. at 561); *see also United States v. Rose*, 522 F.3d 710, 717 (6th Cir. 2008); *Faasse*, 265 F.3d at 482.

Plaintiffs do not dispute that these insurance industry reforms are within the commerce power. Nor do they dispute that the minimum coverage provision is necessary to make these larger regulations of the interstate market effective. These concessions establish that Congress acted within its commerce power. *See Thomas More*, 720 F. Supp. 2d at 894 (recognizing that the minimum coverage provision "operates as an essential part of a comprehensive regulatory scheme" and thus is valid under *Raich*). Indeed, if Congress has authority to enact a regulation of interstate commerce—as it plainly does with respect to its regulation of health insurance policies in the interstate market—"it possesses every power needed to make that regulation effective." *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942). "'If it can be seen that the means adopted are really calculated to attain the end, the degree of their necessity, the extent to which they conduce to the end, the closeness of the relationship between the means adopted and the end to be attained, are matters for congressional determination alone.'" *Comstock*, 130 S. Ct. at 1957 (quoting *Burroughs v. United States*, 290 U.S. 534, 547-48 (1934)).

Absent a violation of some independent constitutional prohibition, "the relevant inquiry is simply 'whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *Comstock*, 130 S. Ct. at 1957 (quoting *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment)); *see also Sabri v. United States*, 541 U.S. 600, 605 (2004). The Act's "guaranteed issue" and "community rating" reforms of the insurance market are, unquestionably, exercises of the commerce power. The minimum coverage provision is not only rationally related, but indeed is "essential," to the implementation of these reforms. 42 U.S.C. § 18091(a)(2)(I). And, as this Court has already held, there is no plausible claim that the minimum coverage provision violates the Due Process Clause or any other independent constitutional prohibition. That is the end of the matter.

Plaintiffs argue that Congress may not rely on the Necessary and Proper Clause as an "independent basis for legislation," and that Congress may not "take any action conceivable in reliance solely on its self-serving notion of what is necessary and proper without regard to the Article I, Section 8 enumerated powers." Pls.' Mem. at 45-46. But that is not defendants' claim. Plaintiffs do not dispute that Congress acted within its enumerated commerce power in regulating the terms of insurance policies sold in the interstate market (indeed, they carefully avoid discussing this point). Nor do they dispute that Congress rationally found the minimum coverage provision to be necessary for those regulations to work. That provision is thus plainly a valid exercise of Congress's power to adopt measures necessary and proper to implement its regulation of commerce.

2. Plaintiffs' Attempt to Dispute Congress's Implementation Power Is Foreclosed by Supreme Court Precedent

Plaintiffs argue that Congress may not undertake one regulation of economic activity (here, the insurance industry reforms protecting between 50 million and 129 million non-elderly Americans whose pre-existing medical conditions threaten their insurance coverage), and then use its implementation authority to adjust the effects of that regulation (here, the minimum coverage provision). Pls.' Mem. at 42. The district court in *Florida* reasoned similarly, holding that Congress may not enact provisions that are "'necessary' to avoid the negative consequences that will potentially flow from its *own* statutory enactments." 2011 WL 285683, at *33 (emphasis in original). This is a newly-invented rule, without support in any holding of the Supreme Court—ever—to defendants' knowledge. It is entirely uncontroversial that Congress may address "negative consequences" that arise as a result of its own statutes. When Congress exercised its power to create the postal system, for example, it became necessary to enact laws to deal with a side effect—that some people would seek to steal the mail. *See McCulloch v. Maryland*, 17 U.S. 316, 417 (1819). Similarly, the authority of Congress under the Spending Clause to appropriate federal moneys carries with it "corresponding authority under the Necessary and Proper Clause" to deal with a nearly inevitable negative consequence of any such statute—the possibility that the funds will be "frittered away in graft." *Sabri*, 541 U.S. at 605. And the Congressional authority to operate federal prisons creates the "negative consequence" that some prisoners will be mentally ill and sexually dangerous at the end of their prison term; Congress may address that consequence through the use of a civil-commitment scheme. *Comstock*, 130 S. Ct. at 1961-62 (noting that harm from release of dangerous inmates from federal custody was

a harm in part created by Congress itself). Any Congressional legislation—particularly legislation adjusting economic rights and responsibilities—will inevitably have side effects. Congress plainly may still enact such legislation, and it also has the power to take action to adjust those effects as it deems necessary to carry out its overall legislative purpose.

Given the absence of any case law for this theory, plaintiffs rely on the *dissenting* opinion in *Raich*, which reasoned that a rule allowing Congress to adopt integrated regulatory schemes would give Congress a "perverse incentive to legislate broadly." *Raich*, 545 U.S. at 43 (O'Connor, J., dissenting). But this Court follows majority opinions, not dissents, and the majority in *Raich* directly refuted the dissent's reasoning. The Court stated its doubt that Congress would ever legislate pretextually simply for the purpose of reaching matters otherwise beyond its commerce power. *Raich*, 545 U.S. at 25 n.34. The Court found it unnecessary to address the matter further, as "there is no suggestion that the [statute at issue] constitutes the type of 'evasive' legislation the dissent fears." *Id.* So too here. There is absolutely no reason to believe that Congress adopted its insurance industry reforms as a pretext to justify the minimum coverage provision.

At bottom, plaintiffs' reasoning, like that of the district court in *Florida*, rests on the premise that Congress enacted the Act's supposedly "dysfunctional" (*Florida*, 2011 WL 285683, at *31) insurance-industry reforms as a mere feint to justify its enactment of Section 5000A as well. This notion cannot plausibly be sustained. Congress adopted these reforms to address a market failure. In the absence of the Act's guaranteed-issue and community-rating reforms, individual and small-group insurers would necessarily have continued their practice of "medical underwriting," which screens or prices out applicants with medical conditions or histories that indicate a higher-than-average need for medical care.

Without the guaranteed-issue and community-rating reforms of the Affordable Care Act, people who attempt to purchase individual health insurance coverage would continue to face significant obstacles to obtaining coverage. Insurers scrutinize the medical condition and history of each applicant to determine their eligibility and premiums in a process known as "medical underwriting." *See* KEY ISSUES, *supra*, at 8, 80 (Defs.' Ex. 9.). An estimated 12.6 million non-elderly adults — 36% of those who tried to purchase health insurance in the previous three years from an insurance company in the individual insurance market — have been denied coverage, charged a higher rate, or offered limited coverage because of a pre-existing condition. DEP'T OF HEALTH AND HUMAN SERVS., COVERAGE DENIED: HOW THE CURRENT HEALTH INSURANCE SYSTEM LEAVES MILLIONS BEHIND 1 (2009) (Defs.' Ex. 23.). And more than 57 million non-elderly Americans have some pre-existing medical condition, and thus, absent the Affordable Care Act, would be at risk for a denial of insurance coverage in the individual market. FAMILIES USA, HEALTH REFORM: HELP FOR AMERICANS WITH PRE-EXISTING CONDITIONS, at 2 (2010) (Defs.' Ex. 22). Overall, the administrative costs that arise from medical underwriting represent 26-30% of the cost of premiums for individual and small group policies. 42 U.S.C. § 18091(a)(2)(J). Given the cost of these policies and restrictions on coverage, it is accordingly unsurprising that only 20% of Americans who lack other coverage options purchase a policy in the individual market, or that the remaining 80% are uninsured. KEY ISSUES, *supra*, at 9.

It is, then, utterly implausible that Congress enacted its insurance industry reforms as a mere pretext, rather than as a solution to the problem of denial of coverage for those with pre-existing conditions. Plaintiffs' claim that Congress acted on a "perverse incentive" to legislate broadly, or the court in *Florida*'s claim that Congress acted simply to create

"negative consequences" so as to justify further regulation, at bottom reflects no more than their disagreement with Congress's policy decision that the denial of coverage for those with pre-existing conditions was a problem worth addressing. But that policy decision is reserved for Congress, not the courts. Congress rationally determined that the policy balance weighed in favor of a measure that would give millions of Americans the ability to purchase coverage without regard to their medical history, in order to ensure that coverage is available when these persons find that they need it the most. Once Congress made that policy choice, the majority opinion in *Raich*—which this Court is obligated to follow, rather than the reasoning of the dissent in that case—makes it absolutely clear that Congress could use its implementation authority to adopt the minimum coverage provision to ensure the effectiveness of the insurance industry reforms.

3. The Minimum Coverage Provision Does Not Represent a Claim of a Limitless National Police Power

Plaintiffs further argue that 26 U.S.C. § 5000A must be invalid, because no principled line can be drawn between that provision and a limitless Congressional "police power." Pls.' Mem. at 21-22. But there is no need to speculate here as to the limits of Congress's commerce power. Those limits are set forth in Supreme Court precedent, and the minimum coverage provision falls well within them. In *Lopez* and *Morrison*, the Supreme Court recognized that Congress may not use the Commerce Clause to regulate a purely non-economic subject matter, if that subject matter bears no more than an "attenuated" connection to interstate commerce, and if the regulation does not form part of a broader scheme of economic regulation. *Morrison*, 529 U.S. at 615; *see also Lopez*, 514 U.S. at 567 (Congress may not "pile inference upon inference" to find a link between the regulated

activity and interstate commerce).

In contrast to those cases, "[n]o piling is needed here to show that Congress was within its prerogative" to regulate interstate commerce. *Sabri*, 541 U.S. at 608. The ACA does not depend on "attenuated" links between its subject matter and interstate commerce; the subject matter of the Act is itself quintessentially economic, the means of payment for economic transactions, that is, the purchase of health care services. The district court in *Florida* analogized this case to *Lopez* and *Morrison*, accusing Congress of "piling 'inference upon inference'" to conclude that "the uninsured" have a substantial effect on interstate commerce. 2011 WL 285683, at *26. But no inferences are required to conclude that the uninsured do receive $43 billion in uncompensated care per year. That is not an attenuated inference, but a hard fact, found by Congress, and undisputed by plaintiffs. The court in *Florida* thus erred in analogizing this case to the "inferential" leaps that are necessary to support the conclusion that gender-motivated violence or carrying guns near schools has downstream economic impacts. *Id.* This case is quite different: The starting point for the inferential leaps in both *Lopez* and *Morrison* involved "noneconomic, criminal" conduct, and the nature of the conduct at issue was "central" to the Court's decisions in those cases. *Morrison*, 529 U.S. at 610; *see also Sabri*, 541 U.S. at 607 (noting that *Lopez* and *Morrison* "emphasized the noneconomic nature of the regulated conduct").

Unlike the statutes at issue in *Lopez* and *Morrison*, the minimum coverage provision directly regulates a quintessentially economic subject matter, the financing of payments in the unique health care market. That market is unlike any other market, in part because "[n]o one can guarantee his or her health, or ensure that he or she will never participate in the health care market." *Thomas More*, 720 F. Supp. 2d at 894. Virtually every American is a

participant in the health care market, as it is inevitable that health care expenses will be incurred. The minimum coverage provision, then, does not create commerce in order to regulate it, as plaintiffs apparently assume when they describe Congress's claimed power as "limitless." Pls.' Mem. at 32. Instead, Congress recognized that commercial transactions already occur, and that substantial effects on interstate commerce arise when some commercial actors are required to cover the costs of health care transactions that the uninsured enter into, but cannot pay for. Congress can take steps to ensure that the uninsured contribute their share of the bill, without in any sense broaching the limits on its ability to address purely non-economic matters established under *Lopez* and *Morrison*.

The court in *Florida* did not deal with the reasoning of *Lopez* and *Morrison*, and instead depicted Section 5000A as a claim of limitless power, because in its view the provision could be analogized to other hypothetical requirements to act, such as a supposed requirement to buy a house backed by a mortgage.[7] But Section 5000A is in no sense analogous to a requirement to buy a house; it does not require individuals to buy a stand-alone product, but instead regulates the way that individuals will pay for health care expenditures that they inevitably will incur. Moreover, individuals do not develop sudden, unforeseen needs to buy exorbitantly expensive new houses. Nor is it the case that, if such a need arises, an individual is automatically entitled to a house regardless of his ability to pay. In the real estate market, as in virtually any market outside of the context of health care, an

[7] This form of slippery-slope reasoning echoes that of the plaintiff in *Helvering v. Davis*, 301 U.S. 619 (1937), which upheld the Social Security Act's provision of retirement benefits for those over 65 years of age. That plaintiff argued that, if Congress had the power to so provide, nothing would stop it from establishing the age of 30 as the retirement age. Brief for the Appellant, *Helvering v. Davis* (1937), 1937 WL 40760, at *53-*54. Sometimes slopes are not all that slippery, particularly those that depend upon the premise that Congress will enact entirely irrational legislation.

individual's ability to obtain a product is almost solely dependent upon that individual's ability to pay. But virtually everyone is a participant in the health care market, and access to that market in a time of need is guaranteed both by federal and state laws and by the dictates of an ethical society. And it is a documented fact that third parties bear the burden of the cost of the uninsured population's participation in that market. The court in *Florida*'s parade of horribles, then, depends entirely upon a disregard of the specific features of the health care market that made Section 5000A necessary.

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

Plaintiffs' challenge to the minimum coverage provision fails for a third reason. Congress also validly enacted the provision as an exercise of its taxing and spending power under the General Welfare Clause of Article I. The test of whether a provision is an exercise of the taxing authority does not turn on the labels that Congress chose, but instead on the "practical operation" of the provision. *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941); *see also United States v. Sotelo*, 436 U.S. 268, 275 (1978) (funds owed by operation of Internal Revenue Code had "essential character as taxes" despite statutory label as "penalties"). And the minimum coverage provision plainly operates as a tax, that is, as a "pecuniary burden laid upon individuals or property for the purpose of supporting the government." *United States v. New York*, 315 U.S. 510, 515-16 (1942). Only individuals who are required to file federal income tax returns for a given year can be subject to the penalty. 26 U.S.C. § 5000A(e)(2). If the penalty applies, it is calculated by reference to the taxpayer's household income. 26 U.S.C. § 5000A(c)(1), (2). The taxpayer must report any penalty on his return for the tax year, as an addition to his income tax liability. 26 U.S.C.

§ 5000A(b)(2). The Congressional Budget Office found that Section 5000A will raise substantial revenues for the general treasury, see Defs.' Ex. 40 at tbl. 4, and Congress expressly adopted the CBO's conclusions in finding that the ACA would have a deficit-reducing effect. ACA, § 1563(a)(1), (2), 124 Stat. 119, 270.

Despite the practical operation of Section 5000A as a tax, the district court in *Florida* rejected the application of the taxing power, finding it "inarguably clear" that Congress did not intend to exercise that power. *Florida v. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 720, 733 (N.D. Fla. 2010). That court rested on Congress's inclusion of Commerce Clause findings when it enacted Section 5000A. But Congress plainly may act under more than one of its grants of authority, *see, e.g.*, *Timmer v. Mich. Dep't of Commerce*, 104 F.3d 833, 837, 840 (6th Cir. 1997) (Equal Pay Act is exercise of Fourteenth Amendment enforcement authority, even given Commerce Clause findings); *In re Leckie Smokeless Coal Co.*, 99 F.3d 573, 586 (4th Cir. 1996) (finding "premiums" on coal operators to be exercise of taxing power despite Commerce Clause findings and absence of taxing power findings). The court in *Florida* also rested on what it misperceived to be Congress's disavowal of the taxing power as a basis of authority for the minimum coverage provision, but congressional leaders repeatedly defended the provision as an exercise of the taxing power during the floor debates. *See* Defs.' Mem. at 42. The minimum coverage provision operates like a tax. It is codified in the Internal Revenue Code; it is administered by the IRS; it is calculated based on household income; it is reported on tax returns; and it is inapplicable to those who fall below the filing threshold. Throughout the ACA, Congress used the taxing power to encourage employers to offer, and individuals to purchase, insurance. The minimum coverage provision is no exception. It is plainly an exercise of the taxing power.

Plaintiffs did not address the taxing power further in their motion for summary judgment. It is not apparent why plaintiffs chose to waive any argument on this score. It is possible, however, that plaintiffs interpreted this Court's previous order to reach a holding on the taxing power. Defendants understand this Court to have ruled with respect to the applicability of the Anti-Injunction Act, but not yet to have ruled on the merits of the taxing power claim. *See* Order of Nov. 22, 2010 at 8 (adopting *Florida*'s holding with respect to the Anti-Injunction Act). *See also Liberty Univ.*, 2010 WL 4860299, at *11 n.13 (rejecting application of Anti-Injunction Act but reserving judgment on taxing power); *Thomas More*, 720 F. Supp. 2d at 895 (same). The remaining issue in this case—whether Congress exceeded its Article I powers—of course, requires a discussion of each of Congress's Article I authorities that applies here, including the taxing power. As plaintiffs have not discussed the issue further, however, defendants will refer the Court to the discussion in their opening brief. Defs.' Mem. at 41-45.

II. PLAINTIFFS LACK STANDING TO SEEK THE INVALIDATION OF PROVISIONS OTHER THAN THE MINIMUM COVERAGE PROVISION

Plaintiffs argue that if their challenge to 26 U.S.C. § 5000A succeeds, then the entire ACA should be stricken as well. But plaintiffs have identified no harm that they suffer from any provision other than Section 5000A. Even if plaintiffs were to prevail in their challenge to that provision, their further challenge to the entire statute seeks nothing more than an advisory opinion, which this Court should not provide in the absence of a party who could claim standing to challenge the remainder of the Act. As in *Printz v. United States*, 521 U.S. 898 (1997), the question of the severability of the ACA raises "important questions, but [the Court has] no business answering them in [this case]." *Id.* at 935. The remainder of the

statute grants rights and imposes obligations on third parties who have not participated in this lawsuit. Accordingly, like the Supreme Court in *Printz*, this Court should "decline to speculate regarding the rights and obligations of parties not before the Court." *Id.* Cf., e.g., New York, supra, at 186-187, 112 S.Ct., at 2434 (addressing severability where remaining provisions at issue affected the plaintiffs).

Even if plaintiffs could somehow overcome their lack of standing to seek to overturn the ACA in its entirety, the issue would still be premature in this briefing. The issue of severability presents a number of complexities, which are best dealt with in separate briefing in a remedies stage, instead of in response to a parting shot in plaintiffs' summary judgment brief. *See Tanner Adver. Grp., LLC v. Fayette Cnty.*, 451 F.3d 777, 797 n.4 (11th Cir. 2006) (Birch, J., concurring) (noting that issues of severability arise at remedies stage, not merits stage).

In any event, if the issue were to be decided now, this Court should hold that the vast majority of the ACA's provisions are severable from Section 5000A. As the Supreme Court recently emphasized, in a case that plaintiffs, curiously, fail to cite:

> Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact. Because the unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions, *the normal rule is that partial, rather than facial, invalidation is the required course*.

Free Enter. Fund v. Pub. Co. Accounting Oversight Bd., 130 S. Ct. 3138, 3161 (2010) (internal quotations omitted; emphasis added). Courts therefore must "strive to salvage" as much of a statute as possible, as only the statute, and not the court's ruling, is a product of the democratic process: "[W]e try not to nullify more of a legislature's work than is

necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329 (2006) (internal quotation omitted).

Against the backdrop of this presumption in favor of severability, and in the absence of a statutory provision expressly addressing severability, courts apply a two-part test. First, after finding a portion of a statute unconstitutional, the court determines whether the remaining portions remain "fully operative as a law"; if so, the remainder is "presumed severable." *INS v. Chadha*, 462 U.S. 919, 934 (1983). Second, that presumption can be defeated if the court finds that it is "*evident*" that Congress would have preferred the rest of the statute (or particular portions) to be invalidated along with the unconstitutional provision. *See Free Enter. Fund*, 130 S. Ct. at 3161-62 (emphasis added).

Under these principles, a limited set of provisions of the Act cannot survive if 26 U.S.C. § 5000A is stricken. As defendants have emphasized, the Act's guaranteed-issue and community-rating insurance industry reforms will stand or fall with the minimum coverage provision. As noted, these reforms protect the millions of Americans with pre-existing medical conditions by requiring insurers to issue policies to those persons at non-discriminatory rates. As plaintiffs correctly recognize, see Pls.' Mem. at 47-48, these regulations of the interstate insurance market must be coupled with the minimum coverage provision to be effective. Absent a minimum coverage provision, these insurance industry reforms would create incentives for many to drop coverage, leading to a spiral of increased premiums and a shrinking risk pool — the insurance market would "implode." Because Congress would not have intended this result, these reforms cannot be severed from the

minimum coverage provision.[8]

The remaining parts of the statute, however, are plainly severable from the minimum coverage provision. The Act, for example, ensures that gravely-ill children in hospice care will not lose their right to receive Medicaid benefits for medical care. 42 U.S.C. § 1396d(o)(1)(C). The Act closes the "donut hole" in Medicare Part D prescription drug coverage. *Id.* § 1396r-8(c)(1)(B). The Act also prevents discrimination against providers who will not furnish assisted suicide services. *Id.* § 18113. It establishes an "Independence at Home" demonstration project for chronically ill senior citizens. *Id.* § 1395cc-5. It provides for a special Medicare enrollment period for disabled veterans. *Id.* § 1395p(*l*). It addresses Medicare reimbursement for bone-marrow density tests. *Id.* § 1395w-4(b)(4)(B). The Act includes many tax provisions as well. *E.g.*, 26 U.S.C. § 45R (tax credit, effective in the 2010 tax year, for small employers providing coverage to their employees). These and countless other provisions of the Act are entirely capable of being applied even if the minimum coverage provision were struck down. It is far from "evident" that Congress would have preferred all of these provisions to be invalidated if the minimum coverage provision were to fall.[9] Indeed, there is no such evidence at all.

Plaintiffs argue that the Court should reach out to strike down the entire statute, because the Act does not include a severability clause, the absence of which plaintiffs

[8] This link establishes that the minimum coverage provision is constitutional, however, as Congress has the power to enact measures to ensure the vitality of its broader regulations of interstate commerce. *See Raich*, 545 U.S. at 22.

[9] Contrary to plaintiffs' baseless assertion, Pls.' Mem. at 47-48, the government's position has been the same in this case as in other cases presenting challenges to 26 U.S.C. § 5000A; the minimum coverage provision stands or falls with the ACA's guaranteed-issue and community-rating insurance industry reforms, but the remainder of the Act survives.

consider to be "instructive." Pls.' Mem. at 47. The Supreme Court disagrees: "In the absence of a severability clause, . . . Congress's silence is just that—silence—and does not raise a presumption against severability." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 686 (1987).

Plaintiffs also rely on the reasoning of the district court in *Florida*, which acknowledged that the vast majority of the ACA can function in the absence of 26 U.S.C § 5000A, but nonetheless invalidated the entire statute because "there is nothing to indicate that they can do so in the manner intended by Congress." *Florida*, 2011 WL 285683, at *34. But it is not defendants' burden to prove this point. The burden is instead on plaintiffs to prove that it is "evident" that Congress would have preferred the rest of the statute (or particular portions) to be invalidated along with the unconstitutional provisions. *Free Enter. Fund*, 130 S. Ct. at 3161-62. The court in *Florida* reasoned that Congress's central purpose was to make insurance coverage more available and more affordable through its insurance industry reforms, and concluded that Congress would not have wanted other provisions directed toward the same end (or even to entirely unrelated ends) to survive. The court cited nothing in the statute or the legislative history to document such an intent. And "[c]ommon sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated." *New York v. United States*, 505 U.S. 144, 186 (1992) (internal quotation and citation omitted). Mere supposition cannot overcome this principle.[10]

[10] Plaintiffs also ask the Court to "enjoin" the defendants from enforcing any provision of the ACA, but make no effort whatsoever to show their entitlement to injunctive relief. Their

CONCLUSION

For the foregoing reasons, defendants' motion for summary judgment should be granted, and plaintiffs' motion for summary judgment should be denied. Defendants respectfully request the opportunity to present argument in support of their motion.

Dated: February 14, 2011

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request for an injunction should summarily be denied.

CERTIFICATION

This case has been assigned to the standard track. However, the page limitations applicable to this memorandum have been modified by order of Judge Dowd. This memorandum is less than 35 pages in length and complies with that modification.

Dated: February 14, 2011

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CERTIFICATE OF SERVICE

I hereby certify that on February 14, 2011, a copy of the foregoing Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment was filed electronically. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt. All other parties will be served by regular U.S. mail. Parties may access this filing through the Court's system.

Dated: February 14, 2011

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