

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT**

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STATE OF SOUTH CAROLINA, by and through  
Alan Wilson, Attorney General of the State of South Carolina;  
STATE OF NEBRASKA, by and through  
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*Plaintiffs-Appellees / Cross-Appellants,*

and

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, et al.,

*Plaintiffs-Appellees,*

v.

UNITED STATES DEPARTMENT OF  
HEALTH AND HUMAN SERVICES, et al.,

*Defendants-Appellants / Cross-Appellees.*

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**On Appeal From the United States District Court  
For the Northern District of Florida**

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**OPENING / RESPONSE BRIEF OF  
APPELLEE / CROSS-APPELLANT STATES**

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*State of Florida, et al. v. United States  
Dep't of Health & Human Svcs., et al.  
Nos. 11-11021 & 11-11067*

**CERTIFICATE OF INTERESTED PERSONS  
AND CORPORATE DISCLOSURE STATEMENT**

Pursuant to Fed. R. App. P. 26.1 and Eleventh Circuit Rule 26.1-1, counsel for the Plaintiff/Appellee States certify that the certificate supplied with the Appellants' Brief, served April 1, 2011, appears complete with the following additions:

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Plaintiffs/Appellees' Attorney

**STATEMENT REGARDING ORAL ARGUMENT**

This Court has scheduled oral argument for Wednesday, June 8, 2011, in Atlanta, Georgia.

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## **JURISDICTIONAL STATEMENT**

The States adopt the government's jurisdictional statement.

### **STATEMENT OF ISSUES PRESENTED**

1. Whether Congress's authority to *regulate* interstate commerce includes the power to compel individuals to *enter into* commerce so that the federal government may regulate them.

2. Whether it is coercive for Congress to condition all existing federal Medicaid funding — billions of dollars representing approximately 40% of all federal funding to the States — on the States' acceptance of new expansions to the Medicaid program.

3. Whether the unconstitutional provisions are non-severable from the remainder of the Act given their close relationship and the Government's repeated insistence that the individual mandate is necessary for the Act's other insurance reforms.

4. Whether all or only some of the Plaintiffs have standing to challenge the individual mandate.

## INTRODUCTION

The Patient Protection and Affordable Care Act is an extraordinary law that rests on unprecedented assertions of federal power. In at least two respects, the Act pushes even the most expansive conception of the federal government's constitutional powers past the breaking point. First, the Act imposes a direct mandate upon individuals to obtain health insurance, marking by all accounts the first time in our Nation's history that Congress has required individuals to enter into commerce as a condition of living in the United States. The federal government identifies no limiting principle that would prevent Congress from employing that same power to force individuals to engage in any manner of commerce so that the federal government may better regulate it. Instead, the federal government embraces a sweeping view of the Commerce Clause — broad enough to reach any subject and encompassing enough to include the power to compel — that would imperil individual liberty, render Congress's other enumerated powers superfluous, and allow Congress to usurp the general police power reserved to the States.

Second, the Act's expansion of the Medicaid program is based on an equally boundless interpretation of Congress's spending power, which would render any remaining limits on Congress's enumerated powers illusory. By piling new conditions on enormous pre-existing blocks of federal grants — literally billions of

dollars — Congress has given the States no practical choice but to comply. No meaningful assessment of the new marginal requirements is possible when the consequences of non-acquiescence are the loss of such enormous sums. That is true no matter how problematic the new requirements are and no matter how intrusive on State prerogatives. To characterize such tactics as anything less than coercion is to deny that spending legislation can ever be impermissibly coercive; indeed, that is the government’s position.

If this Court were to uphold those assertions of federal power, there would remain little if any power “reserved to the States ... or to the people.” U.S. Const. amend. X. Because that is plainly not the federal government that the Constitution envisions, the district court correctly concluded that the Act is unconstitutional.

### **STATEMENT OF THE CASE**

This case involves a facial challenge to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111-152 (collectively, “the ACA” or “the Act”). Plaintiffs are twenty-six States, two individuals, and the National Federation of Independent Business. They brought this action seeking declaratory and injunctive relief, alleging that the Act is invalid in its entirety because four of its five core provisions exceed Congress’s constitutional authority, and none is severable from the rest of the Act.

Plaintiffs’ second amended complaint included six causes of action; the district court dismissed four. Record Excerpts (“R.E.”) 1966–2000; 379–443. The case proceeded to summary judgment on the two remaining claims: (1) that the Act’s mandate that each individual maintain a minimum level of health insurance exceeds Congress’s enumerated powers; and (2) that, as amended by the Act, the Medicaid program is impermissibly coercive and therefore exceeds Congress’s spending power. The district court granted the Plaintiffs summary judgment on their claim that Congress lacked authority to enact the individual mandate, but granted the government summary judgment on the Plaintiffs’ claim that the Act’s Medicaid amendments exceed Congress’s spending authority. R.E. 2002–64.

The court also concluded that the individual mandate could not be severed from the rest of the Act, and it therefore declared the Act invalid in its entirety. R.E. 2064–75, 2080. The government filed a notice of appeal on March 8, 2011, and the Plaintiffs filed a notice of cross-appeal on March 10, 2011. R.E. 2149, 2152.

## **STATEMENT OF FACTS**

### **A. The Affordable Care Act**

The ACA is a 2,700-page collection of wide-ranging federal innovations intended to impose “near-universal” health insurance coverage on the Nation. ACA § 1501(a)(1)(D). The Act has five central components: (1) a mandate that

nearly all individuals maintain a minimum level of insurance, ACA § 1501(b); (2) the creation in each State of “health benefit exchanges,” administered by either the state or federal government, on which individuals and small businesses can pool their purchasing power to obtain insurance, ACA § 1311; (3) a set of mandates and incentives for employers, including the States, designed to require or encourage the expansion of employer-sponsored insurance, ACA §§ 1001, 1511, 1513; (4) a substantial expansion of Medicaid eligibility and coverage, as well as tax credits for insurance purchased by needier individuals, ACA §§ 2001, 1401, 1402; and (5) so-called “guaranteed-issue reforms,” which prohibit insurers from denying, canceling, capping, or increasing the cost of coverage based on an individual’s pre-existing conditions or history, ACA § 1001.

These appeals focus primarily on two of the Act’s core provisions: the individual mandate and the Medicaid expansion.

### **1. The Individual Mandate**

The ACA mandates that each “applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.” 26 U.S.C. § 5000A(a). This mandate to maintain health insurance applies to all individuals except foreign nationals residing here unlawfully, incarcerated individuals, and individuals falling within two narrow

religious exemptions. *Id.* § 5000A(d). A covered individual who fails to comply with the mandate is subject to a financial “penalty.” *Id.* § 5000A(b)(1), (c).

## **2. The Medicaid Expansion**

Originally conceived in 1965, Medicaid was designed as a cooperative program whereby Congress offered funding to any State that volunteered to establish a health insurance plan for needy residents. *See* Social Security Act of 1965, Title XIX, codified at 42 U.S.C. § 1396 *et seq.* At its inception, the program covered approximately 4 million individuals and cost about \$1 billion. John Klemm, Ph.D., *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105, 106 (Fall 2000). It has since expanded dramatically, and is now the single largest federal grant-in-aid program to the States. Medicaid now accounts for more than 40% of all federal funds dispersed to the States — \$251 billion in 2009 alone — and approximately 7% of all federal spending. *See* The Long-Term Budget Outlook, June 2010, CBO, at 7, 30, *available at* <http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf>; Budget of the United States Government: State-by-State Tables Fiscal Year 2010, *available at* [http://www.gpoaccess.gov/usbudget/fy10/sheets/bis/8\\_3.xls](http://www.gpoaccess.gov/usbudget/fy10/sheets/bis/8_3.xls). The majority of States receive at least \$1 billion each year in federal Medicaid funding, which covers at least half of each State’s total Medicaid costs. R.E. 1551–55.

The ACA substantially expands the eligibility and coverage thresholds that States must adopt and enforce to remain eligible to participate in Medicaid, as well as the States' burdens and costs. Whereas Medicaid previously gave States substantial discretion in determining eligibility based on federal poverty levels, the ACA requires States to provide Medicaid to individuals with incomes up to 133% of the poverty level (with a 5% "income disregard" provision that effectively raises that number to 138%, HCERA § 1004(b)). ACA § 2001(a). Although the federal government will initially fund 100% of the expanded benefits, the States are responsible for significant administrative expenses; Congress also provided no increased funding for the millions of individuals, who are currently eligible but not enrolled, who will be forced into the program to comply with the individual mandate. *See* R.E. 523-24, 573-74, 600-02, 613, 637, 643, 675, 705, 709, 792-94, 801-04. Moreover, by 2017, States will be responsible for 5% of the costs of the new benefits, with that number increasing to 10% by 2020. HCERA § 1201.

The Act establishes a new "minimum essential coverage" level that States must provide to Medicaid recipients, thereby eliminating much of the flexibility States previously possessed to determine what level of coverage to provide. ACA § 2001(a)(2). It also imposes a "maintenance of effort" condition, which requires that, until a State's approved health insurance exchange is fully operational, a State "shall not have in effect eligibility standards, methodologies, or procedures ... that

are more restrictive than [those] in effect on the date of enactment of the [ACA].” *Id.* § 2001(b). That requirement locks each State into its previously voluntary coverage decisions, whatever they might have been. Finally, the Act requires the States not only to pay the costs of care and services, but also to assume responsibility for providing “the care and services themselves.” ACA § 2304. The added burdens, costs and liabilities from this new requirement — particularly in the face of federal projections of severe provider shortages — are incalculable, but sure to be substantial, underscoring that the ACA transforms Medicaid well beyond anything the States volunteered to implement. In conjunction with these expansions, the government predicts that federal Medicaid spending will increase by another \$434 billion by the end of the decade. R.E. 1425.

Congress did not impose the Act’s additional Medicaid provisions as a condition of accepting *new* federal funding. It instead conditioned each State’s *entire* federal Medicaid grant — on average, at least a billion dollars — on adoption of the Act’s substantial expansions of state obligations under the program. R.E. 104; *see also* Julie Stone et al., *Medicaid and the State Children’s Health Insurance Program (CHIP) Provisions in PPACA*, Cong. Research Serv., April 28, 2010, at 2, *available at* [http://www.arkleg.state.ar.us/healthcare/medicaid/Documents/CRS%20Report%204\\_28\\_10.pdf](http://www.arkleg.state.ar.us/healthcare/medicaid/Documents/CRS%20Report%204_28_10.pdf) (“the law requires states to expand Medicaid”).

## **B. District Court Proceedings**

Shortly after Congress passed the ACA, Plaintiffs brought this action seeking a declaration that the ACA is unconstitutional.

### **1. Motion to Dismiss**

The district court granted in part and denied in part the Defendants' motion to dismiss Plaintiffs' amended complaint. R.E. 379–443. The court rejected the federal government's standing objections. R.E. 408–18. In doing so, the court noted that the government did not challenge the States' standing to challenge the ACA's amendments to Medicaid. R.E. 408.

Turning to the merits, the district court dismissed the States' Tenth Amendment challenge to the mandate (as applied to the States) that employers provide health insurance to employees, as well as the States' claim that the provisions concerning health benefit exchanges commandeered state governments in violation of the Tenth Amendment. R.E. 420–28. The court determined that those claims were precluded by *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 554 (1985), and *Hodel v. Virginia Surface Mining & Reclamation Association, Inc.*, 452 U.S. 264 (1981).

The district court denied the government's motion to dismiss the States' challenge to the individual mandate, noting that its decision was “not even a close call” given that “[t]he power that the individual mandate seeks to harness is simply

without prior precedent.” R.E. 439. The court also concluded that Congress intended the penalty for violating the mandate to be a regulatory penalty, as opposed to a tax subject to Congress’s taxing authority. R.E. 385–407.

The district court further denied the government’s motion to dismiss the States’ claim that the Medicaid amendments exceed Congress’s authority to attach conditions to the States’ acceptance of federal funding. The court concluded that, “[i]f the Supreme Court meant what it said in [*South Dakota v.*] *Dole*[, 483 U.S. 203, 211 (1987)] and *Steward Machine Co. [v. Davis, 301 U.S. 548, 590 (1937)]* , there is a line somewhere between mere pressure and impermissible coercion,” and the ACA’s requirement that States accept all changes to the Medicaid program as a condition of receiving *any* federal Medicaid funds arguably fell on the impermissibly coercive side of the line. R.E. 434.

## **2. Motions for Summary Judgment**

After the parties filed motions for summary judgment, the district court found that each of the individual Plaintiffs and the NFIB had standing to challenge the individual mandate. It further found that at least two States (Idaho and Utah) also had standing because the individual mandate conflicts with State laws declaring that those States’ citizens may not be compelled to obtain healthcare. R.E. 2017–19. Thus, there was no “need to discuss the standing issue with respect to the other state plaintiffs, or the other asserted bases for standing.” R.E. 2019.

On the merits, the district court noted that the individual mandate is an unprecedented form of federal action — “Never before has Congress required that everyone buy a product from a private company (essentially for life) just for being alive and residing in the United States.” R.E. 2039. The court explained that “an ‘absence of power’ might reasonably be inferred where — as here — ‘earlier Congresses avoided use of this highly attractive power.’” R.E. 2040 (quoting *Printz v. United States*, 521 U.S. 898, 905, 908 (1997)).

Under current Supreme Court doctrine, the district court determined, “some type of already-existing activity or undertaking” is a “prerequisite to the exercise of the commerce power.” R.E. 2044. Congress therefore cannot “penalize a passive individual for failing to engage in commerce.” R.E. 2043. If Congress could do so, the court concluded, “the enumeration of powers in the Constitution would have been in vain for it would be ‘difficult to perceive any limitation on federal power.’” R.E. 2043 (quoting *United States v. Lopez*, 514 U.S. 549, 564 (1995)).

Applying those principles, the court determined that the individual mandate “regulates *inactivity*,” that is, it applies to every person “who ‘fails’ to act pursuant to the congressional dictate” to obtain health insurance. R.E. 2045. The court rejected the defendants’ argument that “unique” features of the health care market justify treating the “mere status of being without health insurance” as economic

activity. R.E. 2051. The court reasoned that while “every market problem is, at some level and in some respects, unique,” the purported uniqueness of the problem does not justify a solution that exceeds Congress’s enumerated powers. R.E. 2050. Moreover, the court found that the supposedly unique features of the health care market — that every individual is susceptible to illness or injury and that the costs of care are sometimes shifted to others — are not unique because one or both of these properties exist in other markets for basic goods and services such as food, transportation, and housing. R.E. 2047–49. The court also rejected the defendants’ argument that Congress can regulate the “decision” not to purchase health insurance, concluding that authority to regulate mere decisions not to engage in activity “would essentially have unlimited application.” R.E. 2054.

The district court further held that the individual mandate could not be justified as a “necessary and proper” means of executing Congress’s power under the Commerce Clause to regulate insurance companies’ underwriting practices. The individual mandate is not an “appropriate” means of achieving that goal, the court held, because it would undermine the “‘essential attributes’ of the Commerce Clause limitations on the federal government’s power,” such that it is “neither within the letter nor the spirit of the Constitution.” R.E. 2063. The court also observed that the government’s reasoning that the individual mandate was necessary to counteract the incentives created by other federal policies would

“have the perverse effect of enabling Congress to pass ill-conceived, or economically disruptive statutes, secure in the knowledge that the more dysfunctional the results of the statute are, the more essential or ‘necessary’ the statutory fix.” R.E. 2061.

Turning to Medicaid, the district court granted the Defendants summary judgment on the States’ coercion claim. R.E. 2007-14. Notwithstanding its earlier acknowledgement that *Dole* and *Steward Machine* recognize a line between pressure and coercion, the court concluded that it would be too difficult to distinguish between pressure and coercion. R.E. 2009.

Finally, the court concluded that the individual mandate cannot be severed from the rest of the Act. The court first noted that, in light of the government’s concession that “the individual mandate and the Act’s health insurance reforms ... will rise or fall together,” “the only question is whether the Act’s other, non-health-insurance-related provisions can stand independently.” R.E. 2064-65.

Examining Congress’s intent, the court found it significant that a severability clause “had been included in an earlier version of the Act, but ... was removed in the bill that subsequently became law.” R.E. 2068. The court next found the government’s concession that the Act’s insurance reforms must fall with the mandate “extremely significant because the various insurance provisions, in turn, are the very heart of the Act itself.” R.E. 2069. Examining the remainder of the

Act, the court concluded that, because of the inter-relatedness of the Act's various provisions, "[i]t would be impossible to ascertain on a section-by-section basis if any particular statutory provision could stand (and was intended by Congress to stand) independent of the individual mandate," and trying do so would "be tantamount to rewriting a statute in an attempt to salvage it." R.E. 2074.

### **STANDARD OF REVIEW**

This Court reviews *de novo* the constitutionality of an act of Congress. *Gulf Power Co. v. United States*, 187 F.3d 1324, 1328 (11th Cir. 1999).

### **SUMMARY OF ARGUMENT**

I. The individual mandate is an unprecedented assertion of a power Congress simply does not possess. Congress has substantial power to *regulate* interstate commerce, but it may not compel individuals to *enter into* such commerce so that Congress may better regulate them. In the over 200 years that Congress has sat, it has never before attempted to exercise its Commerce Clause power in this manner. That is not the product of remarkable restraint; Congress has not exercised such a power because it does not exist. Instead, the Commerce Clause has always been understood as granting Congress authority "to prescribe the rule by which commerce is to be governed," *Gibbons v. Ogden*, 22 U.S. 1, 196 (1824), not to create or compel that commerce in the first instance. Upholding Congress's novel assertion of authority to conscript individuals into commerce, or

indeed into any activity that substantially affects commerce, would eliminate any meaningful limit on Congress's enumerated powers and effectively destroy the Constitution's careful balance.

The government makes no attempt to identify the outer limits of its newly found authority, but instead emphasizes that the health care market is unique. Uniqueness is hardly a source of legal authority, and neither the insurance market nor the broader health care market is unique. Plenty of individuals rationally decide to self-insure, wholly apart from any disincentives created by federal law. And, in contrast to markets for basic necessities like food and shelter, it is not inevitable that every individual will ultimately participate in the health care market. In any event, the government's argument that *most* individuals will *someday* participate in the health care market does not permit Congress to regulate *all* individuals *now*.

The government similarly fails to differentiate the health care market from other markets by pointing to the potential for "cost-shifting." Cost-shifting is an inherent aspect of many markets in which the government chooses to subsidize costs. Indeed, cost-shifting is so ubiquitous that the Supreme Court has already rejected as boundless the argument that Congress may justify legislation otherwise outside its Commerce Clause power on that basis. *See United States v. Lopez*, 514 U.S. 549, 563–64 (1995). Neither the health care market nor cost-shifting

concerns are unique; what is unique is the individual mandate's compulsion of commercial activity. However, if this court upholds the ACA, this heretofore unexercised power will soon become ubiquitous.

Nor is the individual mandate justified by resort to the Necessary and Proper Clause. When a law's principal Commerce Clause defect is that it grants Congress a police power reserved to the States, pointing to the additional power conferred by the Necessary and Proper Clause is a non sequitur. A law that is not consistent with the "letter and spirit" of the Constitution is not a "proper" means of executing an enumerated power. *McCulloch v. Maryland*, 17 U.S. 316, 421 (1819). The individual mandate cannot be reconciled with the Constitution's structural protections or the Framers' conscious choice to give Congress only limited and enumerated powers. The individual mandate cannot be justified as a modest provision incidental to the remainder of the ACA; instead, it is the very centerpiece of the Act. It is also one of the Act's principal threats to individual liberty and the States' unique role in a true system of dual sovereignty.

The mandate is equally indefensible as an exercise of Congress's taxing power, for the simple reason that the mandate is not a tax; it is a requirement that individuals engage in particular conduct.

**II.** The ACA's dramatic expansion of States' obligations and liabilities under Medicaid is not a valid exercise of Congress's spending power. Although

Congress may use the promise of federal funds to persuade a State to adopt federal conditions voluntarily, the Supreme Court has long “recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’” *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590). Unless that doctrine is to be abandoned, the ACA far surpasses that point. The Act conditions all of the States’ federal Medicaid funding — billions of dollars — upon acceptance of the ACA’s expanded Medicaid eligibility and coverage provisions. Accordingly, the only means by which a State may avoid the ACA’s substantial new burdens is by withdrawing entirely from the Medicaid program, which is simply not possible given the amount of money at stake. Congress itself recognized as much by providing no means other than Medicaid through which the neediest individuals might comply with the individual mandate.

Rather than attempt to explain how the ACA complies with the coercion doctrine, the district court instead appears to have deemed coercion a political question not subject to meaningful judicial supervision. However, the notion that coercion claims are nonjusticiable cannot be reconciled with the Supreme Court’s repeated recognition that the coercion doctrine does exist, or with the Court’s adjudication *on the merits* of every coercion claim that has reached it.

**III.** As the district court correctly concluded, the ACA cannot survive the invalidation of its central individual mandate and the reforms directly tied to it. The government argues that some unidentifiable portion of the Act’s 450 other provisions — provisions carefully calibrated to either fund or be funded by those central reforms — should nonetheless be left in place. In doing so, the government ignores the central question in the severability analysis, namely, “whether the statute will function in a *manner* consistent with the intent of Congress” once the unconstitutional portions have been severed. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987). Without the individual mandate and its accompanying insurance reforms, the remnants of the ACA could not function in the manner Congress intended.

Finally, the district court correctly included all Plaintiffs in its declaratory judgment. The States have demonstrated standing to challenge the individual mandate in at least three respects: (1) they are injured by its requirement that millions more individuals enroll in Medicaid; (2) they are injured by the Act’s other insurance reforms, from which the mandate cannot be severed; and (3) they are injured by the mandate’s intrusion upon their sovereignty.

## ARGUMENT

### **I. The Individual Mandate Exceeds Congress's Authority To Regulate Interstate Commerce.**

Simply for being alive, an individual, by federal directive, must purchase qualifying health insurance, or to have it purchased by an employer on their behalf. *See* 26 U.S.C. § 5000A(a), (d), (f). By attempting to *compel* people to participate in commerce, the individual mandate far exceeds the federal government's Commerce Clause authority to “*regulate* commerce.” U.S. Const. art. I, § 8, cl. 3 (emphasis added). Permitting Congress to force citizens to engage in commerce all the better to regulate them is simply not compatible with a system of enumerated and limited powers or a system of dual sovereignty. Sanctioning such a power would eliminate all meaningful limits on Congress's authority and sound the death knell for our constitutional structure and individual liberties.

#### **A. The Power To Regulate Commerce Does Not Include the Power To Compel Individuals To Engage in Commerce.**

##### **1. The constitutional text and precedent are clear that the power to regulate commerce does not include the power to compel commerce.**

The Constitution grants Congress authority to “regulate” interstate commerce. Dating all the way back to Chief Justice Marshall, the Supreme Court has repeatedly confirmed that, consistent with its plain meaning, “the power to regulate” is the power “to prescribe the rule by which commerce is to be governed.” *Gibbons v. Ogden*, 22 U.S. 1, 196 (1824). Thus, commerce “is

regulated by prescribing rules for carrying on [commercial] intercourse,” *id.* at 190 — *not* by forcing anyone to carry on such intercourse in the first place. Justice Field similarly explained that “[t]he power to regulate [interstate] commerce ... is the power to prescribe the rules by which it shall be governed, that is, the conditions upon which it shall be conducted.” *Gloucester Ferry Co. v. Pennsylvania*, 114 U.S. 196, 203 (1885); *see also City of St. Louis v. W. Union Tel. Co.*, 149 U.S. 465, 469–70 (1893).

Even as the challenges of economic modernization have caused the Supreme Court to expand the traditional meaning of “interstate commerce,” *see United States v. Lopez*, 514 U.S. 549, 554–56 (1995), the Court has never questioned that the power to “regulate” commerce is the power to prescribe rules to govern pre-existing, voluntary conduct. Indeed the very breadth of modern Commerce Clause doctrine is what makes so alarming the federal government’s claim that if it may *regulate* conduct, it may also *compel* it. There are now “three general categories of regulation in which Congress is authorized to engage under its commerce power.” *Gonzales v. Raich*, 545 U.S. 1, 16 (2005). Congress may regulate (1) the use of the channels of interstate commerce; (2) the instrumentalities of interstate commerce, or persons or things in interstate commerce; and (3) “*activities* that substantially affect interstate commerce.” *Id.* at 16-17 (emphasis added); *see also United States v. Morrison*, 529 U.S. 598, 609 (2000); *Lopez*, 514 U.S. at 558–59. In the third

category, Congress may regulate purely “intrastate *activity*” that is “economic in nature” and that, viewed in the aggregate, has a substantial effect on interstate commerce. *Morrison*, 529 U.S. at 613 (emphasis added); *see Lopez*, 514 U.S. at 559–61; *Raich*, 545 U.S. at 17.

Each of these categories presupposes a pre-existing voluntary activity to be regulated. In particular, the third category — the one at issue in this case, *see* Govt.’s Opening Br. 24–25 — requires that the congressional regulation be directed at commercial or economic “activity.” *Morrison*, 529 U.S. at 613. The government’s own brief is replete with references to regulated “activity” or “conduct” precisely because those terms are ubiquitous in the case law. *See, e.g.*, Govt.’s Opening Br. 16, 18, 20, 24, 25, 28, 29.

Regulation of intrastate activity that substantially affects interstate commerce is already at the edge of the Commerce Clause authority because it does not directly regulate interstate commerce itself. Because broad regulation of such intrastate activities creates tension with our federalist system, the courts must resist “additional expansion” of that third category. *See Lopez*, 514 U.S. at 567–68; *accord id.* at 580 (Kennedy, J., concurring). That makes the “activity” limitation crucial, because without it that third category would lose any claim to be grounded in the Constitution. Congress would no longer be regulating interstate commerce or even activities that substantially affect interstate commerce — instead, it would

be reaching out to compel private conduct where there had been no activity, and thus not effect interstate commerce.

Moreover, Congress's "plenary" regulatory authority over matters within the scope of its commerce power, *see Gibbons*, 22 U.S. at 197, is strong evidence that Congress may not drag unwilling individuals within the scope of that power. Congress has "direct and plenary powers of legislation over the whole subject" of interstate commerce and therefore "has power to pass laws for regulating the subjects specified, in every detail, and the conduct and transactions of individuals [in] respect thereof." *Civil Rights Cases*, 109 U.S. 3, 18 (1883). Indeed, Congress has "full control" of "the subjects committed to its regulation." *North Am. Co. v. SEC*, 327 U.S. 686, 705 (1946) (quoting *Minn. Rate Cases (Simpson v. Shepard)*, 230 U.S. 352, 399 (1913)). If the Constitution gave Congress authority to draft individuals not just for military service, but for any activity directly affecting interstate commerce, and then to exercise full control over them, the Framers surely would have proposed far more protections in the Bill of Rights or rejected this dangerous new power altogether. But they did neither, precisely because the commerce power was not some vortex of authority that rendered the entire process of enumeration beside the point. *Cf.* THE FEDERALIST No. 45, at 293 (James Madison) (Clinton Rossiter ed., 1961) (the commerce power "seems to be an addition which few oppose, and from which no apprehensions are entertained").

**2. Congress has never before attempted to use the Commerce Clause to compel private commercial activity.**

The absence of historical precedent for the exercise of such an extraordinary authority is revealing; if Congress actually possessed this power, it is doubtful that it would have taken two centuries to exercise it. When “earlier Congresses avoided use of” a “highly attractive power,” that avoidance is “reason to believe that the power was thought not to exist.” *Printz*, 521 U.S. at 905; *see also Alden v. Maine*, 527 U.S. 706, 743–44 (1999).

Congress’s own legal advisers have repeatedly confirmed that there is no historical precedent for this asserted power. In 1994, the nonpartisan Congressional Budget Office observed that a “mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action.” CBO, *The Budgetary Treatment of an Individual Mandate To Buy Health Insurance* 1 (1994) [hereinafter “CBO Report”]. The CBO explained that the federal government “has never required people to buy any good or service as a condition of lawful residence in the United States.” *Id.* Rather, Congress has generally limited itself to imposing “[f]ederal mandates” that “apply to people as parties to economic transactions.” *Id.* at 2 (emphasis added).

Similarly, during the debate over the current version of the individual mandate, the nonpartisan Congressional Research Service advised that “[d]espite the breadth of powers that have been exercised under the Commerce Clause,” it is

“a novel issue whether Congress may use this clause to require an individual to purchase a good or service.” CRS, *Requiring Individuals To Obtain Health Insurance: A Constitutional Analysis* 3 (2009). And while differing on the constitutional bottom line, courts have uniformly agreed that the individual mandate is unprecedented. *See Virginia ex rel. Cucinelli v. Sebelius*, 728 F. Supp. 2d 768, 781 (E.D. Va. 2010); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 893 (E.D. Mich. 2010); *Mead v. Holder*, No. 10-950, 2011 WL 611139, at \*18 (D.D.C. Feb. 22, 2011).

The absence of prior Commerce Clause legislation mandating private activity is not for lack of a motive; Congress previously declined to exercise that power even in situations where it obviously would have been expedient. For example, when it became evident that “relatively few individuals” were voluntarily purchasing flood insurance under the National Flood Insurance Act of 1968, Pub. L. No. 90-448, 82 Stat. 572, Congress made the purchase of flood insurance a prerequisite for participation in certain voluntary economic transactions. *See* 42 U.S.C. § 4012a(a) (no federal financial assistance for acquisition or construction of a building without flood insurance); *id.* § 4012a(b)(1) (federally regulated lenders may not make loans secured by property without flood insurance). How much simpler to directly compel the purchase of such insurance; yet Congress never mandated the purchase of flood insurance by everyone in the flood plain.

The very same arguments the government is now making in defense of the individual mandate to purchase health insurance would have applied with equal force to a flood insurance mandate: Most individuals living in flood hazard areas will suffer flood-related losses at some point (participants in the flood-victim market in the government's locution), and those losses are likely to be distributed throughout society by mechanisms such as governmental disaster relief. That Congress did not mandate the purchase of flood insurance by persons living in flood plains, despite the obvious practical benefits of doing so, strongly suggests that Congress thought it lacked that power.

Similarly, a power to compel commerce would be particularly attractive during a recession, when congressional efforts to stimulate the economy are often frustrated by individuals' decisions to save rather than spend. *See* Edmund L. Andrews, *Economists See a Limited Boost from the Stimulus*, N.Y. TIMES, Aug. 7, 2009, at A1. How much better for the long-run deficit and the short-term economy to mandate spending by individuals; yet Congress instead tinkered with different mechanisms for encouraging individuals voluntarily to spend more. *See* Michael Cooper, *From Obama, the Tax Cut Nobody Heard Of*, N.Y. TIMES, Oct. 19, 2010, at A1 (reporting that in light of "evidence that people were more likely to save than spend the tax rebate checks they received," Congress "arranged for less money to

be withheld from people’s paychecks”). Indeed, even during the Great Depression and two world wars, the government did not claim such a power.

The government’s effort to dig up counter-examples under the Commerce Clause only confirms that there are none:

- The government cites the Second Militia Act of 1792, ch. 33, 1 Stat. 271, which required “each and every free able-bodied white male citizen” between 18 and 45 years of age to “be enrolled in the militia” and to obtain, “within six months thereafter,” a firearm, ammunition, and other military equipment. *See* Govt.’s Opening Br. 44; *see also* *Parker v. Dist. of Columbia*, 478 F.3d 370, 386–87 (D.C. Cir. 2007). Congress enacted that requirement pursuant to its power to “provide for organizing, arming, and disciplining, the militia,” U.S. Const. art. I, § 8, cl. 16, not its power to “regulate commerce,” *id.* cl. 3. Moreover, the arming requirement did not apply to every individual in the United States, only to those “enrolled in the militia.”
- The government points to the provision of the Emergency Banking Relief Act of March 9, 1933, 48 Stat. 2, authorizing the Secretary of the Treasury to require all persons “to pay and deliver to the Treasurer of the United States any or all gold coin, gold bullion, and gold certificates” owned by them. *See* Govt.’s Opening Br. 44 (citing *Nortz v. United States*, 294 U.S. 317 (1935)). Congress passed that provision pursuant to its power “to provide a currency for the whole country” and to “put out of existence ... a circulation in competition with notes issued by the government.” *Legal Tender Cases*, 79 U.S. 457, 543 (1871); *see also* U.S. Const. art. I, § 8, cl. 5. *See* *Norman v. Balt. & Ohio R. Co.*, 294 U.S. 240, 302–03 (1935).
- The government cites the Endangered Species Act, the Federal Access to Clinic Entrances Act, and federal child pornography laws. Govt.’s Opening Br. 44. Each of these federal statutes prohibits private conduct — taking a species, blocking a clinic, or possessing child pornography. None compels unwilling individuals to engage in commercial or economic activity.

If anything, the government's examples only confirm that “[f]ederal mandates that apply to individuals as members of society are extremely rare,” CBO Report at 2, and non-existent under the Commerce Clause. The “numerousness” of federal statutes regulating voluntary commercial and economic activity, “contrasted with the utter lack of statutes” mandating such activity, is compelling evidence of the “assumed *absence* of such power.” *Printz*, 521 U.S. at 907-08.

**B. The Power To Regulate Commerce Does Not Authorize the Lifelong Regulation of Every Citizen on the Ground that Most Will, at Some Point, Engage in Commerce in the Future.**

Under correct legal principles, Congress's findings underlying the Act are plainly insufficient, and the government does not suggest otherwise. Congress found that the *mandate itself* “is commercial and economic in nature, and substantially affects interstate commerce.” ACA § 1501(a)(1). That focus on regulatory impact, rather than pre-existing commercial activity only underscores the absence of constitutional authority under correct legal standards — instead of regulating *activity* with substantial effects on interstate commerce, Congress apparently considered it sufficient that the *regulation* itself would have such effects. Requiring everyone to buy an airplane would certainly have a substantial effect on interstate commerce, but that hardly brings such a mandate within Congress's Commerce Clause authority. Congress also found that the “decision” not to purchase a product, such as health insurance, is itself “economic activity.”

ACA § 1501(a)(2)(A). But treating a mental process as the relevant “activity” only underscores the absence of actual activity and the troubling lack of a limiting principle.

Rather than defend those congressional findings, the government claims that the individual mandate is actually a regulation of *future* commercial or economic activity in which, the government presumes, most individuals subject to the mandate will ultimately engage. This argument finds no support in precedent and has astonishing implications for federalism and individual liberty.

**1. It is not inevitable that everyone will purchase health insurance or consume health care services.**

The government’s argument proceeds in three steps. First, it identifies a broad national market for “health care services.” Govt.’s Opening Br. 26. As defined, this market encompasses a wide variety of goods and services, including hospital care; physician and clinical services; other professional services (*e.g.*, dentistry, chiropractic, mental health); prescription and over-the-counter drugs; and medical equipment such as eyeglasses and hearing aids. *See* Centers For Medicare & Medicaid Servs., National Health Expenditures 2009 Highlights, at 1 (2011), *cited in* Govt.’s Opening Br. 7. The size of this market in 2009 was \$2.5 trillion, more than one-sixth of the nation’s gross domestic product. *Id.* Second, the government claims that “[v]irtually all” citizens participate in this broadly defined market. *Id.* at 16; *see also id.* at 37–38. Third, the government contends that

Congress may impose on all citizens a requirement to purchase health insurance as a means of “regulat[ing]” the way those citizens “pay for services in the interstate health care market.” *Id.* at 25–26.

The government’s theory boils down to the claim that if it can identify an “interstate market” in a broadly defined commodity, such as “health care services,” that *most* individuals will need to consume *at some point* in their lives, it can then regulate *everyone* at *every* moment of their lives, from cradle to grave, as if they were at that very moment active participants in the interstate market in question. That is troubling and far too broad. Just as “depending on the level of generality, any activity can be looked upon as commercial,” *Lopez*, 514 U.S. at 565, the government’s theory shows that, depending on the level of generality, anyone, no matter how dormant, could be looked at (under the government’s approach) as participating in a market.

In the first place, as the government seemed to recognize below, the relevant market here is insurance, not health care. The individual mandate does not force participation in the health care market or even mandate the use of insurance once purchased. Instead, it forces people to pay now for health care that they may or may not receive at some point in the future. But many people voluntarily decide to forego the purchase of health insurance, and many do so for reasons having nothing to do with the incentives created by other federal programs.

The government attempts to distinguish health insurance on the ground that everyone will participate in the health care market at some point. But that is not strictly true, and does not render the market unique. The government does not, and cannot, contend that *all* these individuals will necessarily participate in the health care market (much less that they will all fail to pay for any services). Some will not participate due to religious scruples or individual circumstances. Indeed even the government concedes that participation in the health care market is not truly universal, as it feels the need to qualify its still-expansive claim that “[v]irtually all Americans participate” in the health care market. And participation in the health care market is not as truly universal as participation in the market for basic necessities, like food and clothing.

Moreover, the government cites no statistics whatsoever that would show that all uninsured individuals that receive medical care do not pay for the care, even though that is the key economic problem the individual mandate is supposed to address. The number of such persons is obviously significantly lower than the number of uninsured individuals who receive *any* medical care, since many healthy individuals make a rational choice to self-insure and are fully capable of paying for the care they receive. According to the government’s own statistics, uninsured persons pay 37% of their health care costs out of pocket, and third parties pay for

another 26% of those costs on their behalf. *See Families USA, Hidden Health Tax: Americans Pay a Premium*, at 22, 6, *cited in Gov't Opening Br.* 10, 11.

The government argues that “Congress need not show that every uninsured person, or which uninsured persons, will receive uncompensated care,” but can instead consider the “cumulative impact” of such care on interstate commerce. *Govt.’s Opening Br.* 27. This argument severely misunderstands the role of aggregation in Commerce Clause analysis. Under Supreme Court precedent, consideration of the aggregate impact of an economic activity on interstate commerce allows congressional regulation to reach *individual instances of that economic activity* that do not, by themselves, have a substantial effect on interstate commerce. *See Raich*, 545 U.S. at 17; *Morrison*, 529 U.S. at 613; *Lopez*, 514 U.S. at 559–61. But aggregation does not allow congressional regulation to reach individuals who are not engaged in that economic activity — much less individuals who *never* will be. Thus, aggregation allows Congress to regulate a single farmer’s apparently de minimus production of a nationally marketed commodity. *See, e.g., Wickard v. Filburn*, 317 U.S. 111, 127–28 (1942). But it would not justify a law requiring others to produce or purchase that commodity.

According to the government, the relevant economic activity is the “practice of consuming health care services without insurance.” *Govt.’s Opening Br.* 28. At most, therefore, Supreme Court precedent allows Congress to regulate *that activity*

— for example, by imposing restrictions or penalties on individuals who attempt to consume health care services without insurance. But that does not give Congress carte blanche to compel participation in that activity.

Moreover, even if it were permissible (it is not) for Congress to adopt a false presumption that every individual will participate in the health care market at some point in time, Congress still would not have the power to force individuals into the market at *other* times. An individual becomes subject to regulation only at the point at which the individual engages in a “commercial transaction” or other “economic activity” in or substantially affecting interstate commerce. *Lopez*, 514 U.S. at 560–61. The Court has never held commercial regulation justified based on a mere likelihood of economic activity at some unknown, perhaps distant, point in the future.

**2. Exercising regulatory authority over everyone on the theory that most people will eventually engage in an activity would impermissibly give Congress an unbounded police power.**

The government’s novel theory — that Congress may exercise its plenary commerce power over *all* individuals at *all* times based on the likelihood that *most* citizens will participate in a broadly defined national market at *some* time — fails for the additional reason that it would vastly expand congressional power at the expense of States and our system of dual federalism. The “Constitution created a Federal Government of limited powers, while reserving a generalized police power

to the States.” *Morrison*, 529 U.S. at 618 n.8 (quoting *New York v. United States*, 505 U.S. 144, 155 (1992)) (internal quotation marks omitted). Thus, the “scope of the interstate commerce power ‘must be considered in light of our dual system of government, and may not be extended so as to ... obliterate the distinction between what is national and what is local and create a completely centralized government.’” *Lopez*, 514 U.S. at 557 (quoting *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937)). In particular, the Commerce Clause may not be read to grant the federal government “a general police power.” *Id.* at 567; *see also id.* at 564.

But that is precisely what the government’s theory would do. Every individual would be at all times subject to federal regulation of his or her private decisions related to health care or anything else that substantially affects interstate commerce (which it to say, almost everything). There is no logical reason why such regulation would have to be limited to the decision whether to purchase health insurance. Congress could regulate other decisions bearing on an individual’s supposed “active participation in the health care market,” such as whether to have an annual physical or to undertake certain courses of treatment. The federal government’s interest in controlling the cost of health care would likewise give Congress authority to order individuals to eat more vegetables and fewer desserts, to exercise at least 45 minutes per day, to sleep at least eight hours per day, and to

drink one glass of wine a day but never any beer. Congress could rationally conclude that such mandates would control healthcare costs more directly, and perhaps more effectively, than ordering people to pay for services in a particular way.

Even apart from health care, most citizens participate in a number of interstate markets at some point in their lives, including markets for housing, food, clothing, education, and transportation. Indeed, the need for food and clothing is at least as pressing and ubiquitous as health care. By the government's logic, Congress could legislate as if all citizens were participants in those interstate markets at all times, and tell them what type of housing, food, and clothing to consume, and how to pay for them. *Cf.* R.E. 2048 (noting that government counsel, when questioned, did not foreclose the possibility that Congress could require people to buy cars).

This is precisely the sort of limitless reading of the Commerce Clause that the Supreme Court has foreclosed. So long as the commerce power is “subject to outer limits,” *Lopez*, 514 U.S. at 557, it cannot be invoked to justify the imposition of a cradle-to-grave regulatory regime on all or nearly all individuals in the United States.

**3. “Cost-shifting” is neither unique to the health care context nor a basis for departing from fundamental constitutional precepts.**

The government suggests that “cost-shifting” is a “unique” feature that distinguishes the health care services market from other markets and justifies the especially intrusive regulation represented by the individual mandate. *See* Govt.’s Opening Br. 34–37. But uniqueness is not a talisman that justifies the government’s use of unconstitutional means; if anything, the government’s repeated emphasis on purported uniqueness only underscores its lack of a viable legal theory. And as noted above, the only thing that is really unique here is Congress’s unprecedented attempt to use its authority to regulate commerce as a basis for conscripting people into participating in commerce.

Cost-shifting is certainly not unique to this context. It is an inherent aspect of many markets due to the frequent availability of “backstops” provided by law, including bankruptcy protection and other government-funded financial assistance and services.” R.E. 2055; *see also* R.E. 2049. On the same rationale, therefore, the government could require everyone to adopt arguably prudent practices to protect their financial status, as well as that of their dependents, by, for example: maintaining minimum levels of life insurance; avoiding risky investments; and not incurring more than a certain amount of debt. Similarly, because the eventual need for burial or cremation services is at least as likely as the need for health care, the

government would evidently assert authority to require everyone to pre-pay for a coffin or urn, to avoid shifting costs onto the public.

The Supreme Court rejected a similar cost-shifting and insurance rationale in *Lopez* and *Morrison*. In *Lopez*, the government argued that Congress could regulate violent crime under the commerce power because “the costs of violent crime are substantial, and, through the mechanism of insurance, those costs are spread throughout the population.” 514 U.S. at 563–64. The Court reasoned that under this cost-shifting and insurance rationale, “Congress could regulate not only all violent crime, but all activities that might lead to violent crime, regardless of how tenuously they relate to interstate commerce.” *Id.* at 564. *Morrison* similarly rejected the government’s argument that gender-motivated violence affects interstate commerce by, among other things, “increasing medical and other costs.” 529 U.S. at 615.

The cost-shifting and insurance rationale is even weaker here insofar as the government would apply it to almost *all* Americans solely for being alive, not only to people who engage in specific targeted activities. And unlike violent crime, the cost-shifting problem is also of Congress’s making — Congress made the decision to guarantee free healthcare to uninsured individuals through the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. It is absurd for the government to argue that Congress’s decision to make healthcare

available for *free* gives it authority to force everyone to *pre-pay* for that service (regardless of whether they ever use or want it).<sup>1</sup>

For that reason, the Government's repeated citation of Justice Kennedy's *Lopez* concurrence for the proposition that "principles of economic practicality" govern is at best ironic. Gov't Br. 43. The practicality here is that "[t]he statute before us upsets the federal balance to a degree that renders it an unconstitutional assertion of the commerce power." *Lopez*, 514 U.S. at 580 (Kennedy, J., concurring).

**C. The Individual Mandate Is Not a Necessary and Proper Means of Executing the Commerce Power.**

The government nonetheless argues that the individual mandate is justified under the Necessary and Proper Clause. But even that "last, best hope of those who defend ultra vires congressional action," *Printz*, 521 U.S. at 923, cannot be stretched so far.

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<sup>1</sup> The government tries to portray Congress as having bowed to a "societal judgment" that uninsured individuals should be guaranteed free medical care, Govt.'s Opening Br. 36, apparently in an effort to soften the blow of its implication that Congress can expand its own authority over individuals by offering them gratuitous benefits and then demanding pre-payment. There is, however, no indication that Congress's decision to offer free medical care was based on a stronger "societal judgment" than that which underlies any other democratically enacted legislation. And if anything distinguishes the judgment reflected by EMTALA, it is that it implicates issues squarely within the reserved power of the States.

As the Supreme Court has long held, a law that is inconsistent with the “letter and spirit” of the Constitution is not a “proper” means of executing an enumerated power. *McCulloch*, 17 U.S. at 421. The Court has also made clear that when a law violates fundamental constitutional principles, “it is not a ‘La[w] ... *proper* for carrying into Execution the Commerce Clause,’ and is thus, in the words of the Federalist, ‘merely [an] ac[t] of usurpation’ which ‘deserve[s] to be treated as such.’” *Printz*, 521 U.S. at 923–24 (alterations in original) (citation omitted); *see also Alden*, 527 U.S. at 733–34 (same). One such principle, which is “deeply ingrained in our constitutional history,” is that the “Constitution created a Federal Government of limited powers, while reserving a generalized police power to the States.” *Morrison*, 529 U.S. at 618 n.8 (quoting *New York*, 505 U.S. at 155) (internal quotation marks omitted). These “precepts of federalism embodied in the Constitution inform which powers are properly exercised by the National Government” under the Necessary and Proper Clause. *United States v. Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring).

As explained above, the individual mandate would violate the fundamental constitutional principle that the federal government is one “of limited powers.” *Morrison*, 529 U.S. at 618 n.8. It is far from “Proper” to eviscerate that basic constitutional precept.

Moreover, the mandate is not “incidental” (*McCulloch*, 17 U.S. at 411) to some other legitimate regulation under the Commerce Clause. Congress sought to “increase the number and share of Americans who are insured,” ACA § 1501(a)(2)(C), and it did so by the most direct route available: requiring them to be insured. Thus, this is not a means to some legitimate end, but an end in itself. The Supreme Court has long held that Congress may not invoke the Necessary and Proper Clause to exercise any “great substantive and independent power,” only powers that are “incidental to those powers which are expressly given” and that “subserve the legitimate objects of” the federal government. *McCulloch*, 17 U.S. at 411. But the power exercised here is distinct from any Commerce Clause power ever exercised and could not have been granted without prompting contemporaneous objection. The fundamental problem is that Congress has invoked a power that it was not granted under the Commerce Clause, the Necessary and Proper Clause or anywhere else.

The government also contends that the individual mandate is incidental to “the requirement that insurers extend coverage and set premiums without regard to pre-existing medical conditions.” Govt.’s Opening Br. 28. The government insists that this requirement “would not work without” the individual mandate because the requirement will encourage consumers to refrain from buying insurance until they are injured or sick. *Id.* at 30–31; *see* ACA § 1501(a)(2)(G). But on this reasoning,

the individual mandate is designed not to “subserve” and facilitate the Act’s insurance industry reforms, *McCulloch*, 17 U.S. at 411, but to *counteract* their anticipated negative consequences.

As the district court correctly recognized, the government’s reasoning would mean that “the more harm [a] statute does, the more power Congress could assume for itself under the Necessary and Proper Clause.” R.E. 2061. The Constitution does not permit this type of blatant bootstrapping — create a problem and then assert that it is necessary and proper to fix the problem by asserting an authority the Constitution otherwise denies the federal government. Moreover, the individual mandate is the centerpiece of the Act, as the government has repeatedly stressed, not a collateral provision or distinct means to some other end. As discussed below, the government’s arguments about the necessity of the individual mandate to the ACA’s other provisions show that the Act is not severable; but they hardly increase Congress’s authority to enact those measures in the first place.

The multi-factor inquiry used by the Supreme Court in its most recent exposition of the Necessary and Proper Clause confirms that the individual mandate is not necessary and proper. *See Comstock*, 130 S. Ct. at 1949. *Comstock* upheld a civil-commitment statute for prisoners with certain mental health issues after considering four contextual factors, *none* of which supports invocation of that Clause here.

While there was a “long history of federal involvement” in prison-related mental health statutes, *id.*, there is no history of the federal government mandating the purchase of health insurance (or any other commodity). Similarly, the individual mandate is not “reasonably adapted” to Congress’s “responsibilities.” *Id.* at 1961–62. Unlike *Comstock*, where the common law imposed obligations on the government as custodian, the federal government has no legal duty to undertake the unprecedented step of providing or mandating health care to everyone legally in the country.

Nor does the individual mandate have only a “narrow” scope. *Id.* at 1949, 1364-65; *cf. Lopez*, 514 U.S. at 566 (“the question of congressional power under the Commerce Clause is ‘necessarily one of degree’”) (citation omitted). It applies to almost everyone legally living in the United States, solely because they live in the United States. 26 U.S.C. § 5000A(a), (d).

The individual mandate certainly does not “accommodat[e] state interests” by leaving them any choice in the matter, *Comstock*, 130 S. Ct. at 1962; instead, it overrides state interests in favor of a one-size-fits-all federal mandate, even in those States like Idaho, Utah, and Virginia that have enacted laws expressly guaranteeing their citizens the freedom to choose not to purchase health insurance. *See* Idaho Code Ann. § 39-9003; Utah Code Ann. § 63M-1-2505.5; Va. Code Ann. § 38.2-3430.1:1.

The manner in which the individual mandate runs roughshod over state interests is particularly egregious given that protection of the public health lies at the core of the States’ traditional police power. *See, e.g., Sporhase v. Nebraska ex rel. Douglas*, 458 U.S. 941, 956 (1982); *Head v. N.M. Bd. of Exam’rs in Optometry*, 374 U.S. 424, 428 (1963). The lack of any limiting principle on this power and the reality that it amounts to a federal police power vitiates any reliance on the Necessary and Proper Clause. *See Comstock*, 130 S. Ct. at 1964 (“Nor need we fear that our holding today confers on Congress a general ‘police power, which the Founders denied the National Government and reposed in the States.’” (*quoting Morrison*, 529 U.S. at 618)). When, as here, the fundamental problem with the federal government’s Commerce Clause theory is the lack of a limiting principle, its resort to the Necessary and Proper Clause to *augment* that power, and make it more like a federal police power is a non-sequitur. Unlike *Comstock*, or any other case on which the government relies,<sup>2</sup> this *is* a case in which “the National Government relieves the States of their own primary responsibility to enact laws and policies for the safety and well being of their citizens” and “the exercise of

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<sup>2</sup> This suffices to distinguish not only *Comstock* but precedents of this Court that rely on the Necessary and Proper Clause to allow Congress to effectuate a government policy that depends on a more customary exercise of the Commerce power. But when the problem is that the Commerce Clause power asserted has no limits, pointing to additional authorities that augment the Commerce Clause is non-responsive.

national power intrudes upon functions and duties traditionally committed to the State.” *Comstock*, 130 S. Ct. at 1968 (Kennedy, J., concurring in the judgment).

**D. The Individual Mandate Is Not a Valid Exercise of Congress’s Taxing Power.**

The government briefly argues that even if the individual mandate is not a valid exercise of Congress’s commerce power, it is nonetheless a valid exercise of Congress’s power to “lay and collect Taxes.” U.S. Const. art. I, § 8, cl. 1; *see* Govt.’s Opening Br. 50–54. Like every other court to consider the issue, the district court correctly rejected the government’s argument. *See Mead*, 2011 WL 611139, at \*22–\*23; *Goudy-Bachman v. U.S. Dep’t of Health & Human Servs.*, No. 1:10-CV-763, 2011 WL 223010, at \*10–\*12 (M.D. Pa. Jan. 24, 2011); *Virginia*, 728 F. Supp. 2d at 786–88; *Liberty Univ., Inc. v. Geithner*, No. 6:10-cv-00015, 2010 WL 4860299, at \*9–\*11 (W.D. Va. Nov. 30, 2010); *U.S. Citizens Ass’n v. Sebelius*, No. 5:10 CV 1065, 2010 WL 4947043, at \*5 (N.D. Ohio Nov. 22, 2010); *Thomas More*, 720 F. Supp. 2d at 890–91.

Whether the statutory penalty for not complying with the individual mandate is a tax is ultimately irrelevant because Plaintiffs are challenging the mandate itself, which is clearly not a tax. The ACA mandates that nearly every individual in the United States “*shall* ... ensure that the individual ... is covered under minimum essential coverage” as defined by federal law. 26 U.S.C. § 5000A(a) (emphasis added). Congress then imposed a “penalty” on any individual who

“fails to meet the requirement” of that individual mandate. § 5000A(b)(1). Plaintiffs’ main constitutional challenge is to the mandate itself, which makes it unlawful not to secure qualifying health insurance coverage; the “penalty” for failure to comply is invalid simply as a consequence of the mandate’s invalidity. *See* R.E. 387 n.3 (acknowledging that plaintiffs’ “challenge ‘is to the mandate itself’ and not the ‘incidental penalty that accompanies the individual mandate’”).

The cases cited by the Government are beside the point because they do not involve the constitutionality of a regulatory prohibition or requirement, as opposed to a tax. For example, *United States v. Sanchez*, 340 U.S. 42, 45 (1950), involved a tax on transferring a drug where the “transfer is *not* made an unlawful act under the statute” (emphasis added); instead of mandating or prohibiting any activity, Congress simply taxed it. Similarly, in *Sonzinsky v. United States*, 300 U.S. 506, 513 (1937), the Court emphasized that “[t]he case is not one where the statute contains regulatory provisions related to a purported tax in such a way as has enabled this Court to say in other cases that the latter is a penalty resorted to as a means of enforcing the regulations.” It would be unprecedented to uphold as a valid exercise of the taxing power an act of Congress that on its face purports to impose a direct regulatory mandate on individual conduct.

The distinction is not a mere formality; there are important differences between a regulation directly mandating certain conduct and a tax encouraging that

conduct. Most obviously, when Congress provides incentives through the tax code, the choice whether to take advantage of those incentives remains with each individual; but when Congress expressly mandates an action, law-abiding individuals must comply. Tax and regulatory legislation are also treated differently under the Constitution. *See* U.S. Const. art. I, § 7, cl. 1 (“All bills for raising revenue shall originate in the House of Representatives ...”). Finally, whether a measure is structured as a tax or a regulation has tangible consequences in terms of public perception and political accountability, as the district court observed. R.E. 405.

Even if the classification of the penalty as a regulatory penalty or a tax mattered, the district court correctly concluded that the structure and legislative history of the ACA demonstrate that Congress made a deliberate choice to treat the financial exaction in ACA § 1501(b) (§ 5000A(b)) as a regulatory penalty rather than a tax. Among other things, Congress:

- (i) specifically changed the term in previous incarnations of the statute from “tax” to “penalty”;
- (ii) used the term “tax” in describing several other exactions provided for in the Act [but not the individual mandate];
- (iii) specifically relied on and identified its Commerce Clause power and not its taxing power;
- (iv) eliminated traditional IRS enforcement methods for the failure to pay the “tax”; and

(v) failed to identify in the legislation any revenue that would be raised from it, notwithstanding that at least seventeen other revenue-generating provisions were specifically so identified.

R.E. 390–400; *see also Virginia*, 728 F. Supp. 2d at 786–88.

Finally, the legislation would still be unconstitutional even if Congress had not imposed a direct regulatory mandate and even if it had not chosen to treat the penalty as a penalty rather than a tax. The taxing power is broad, but not so broad as to eliminate constitutional limits on Congress’s regulatory authority. Thus, the Supreme Court has long recognized that “the taxing power may not be used as the instrument to enforce a regulation of matters of state concern with respect to which the Congress has no authority to interfere.” *United States v. Butler*, 297 U.S. 1, 70 (1936).

While the Supreme Court has cut back on some of the limits it used to impose on the taxing power, it has never abandoned, and instead has reaffirmed, the principle that “there comes a time in the extension of the penalizing features of the so-called tax when it loses its character as such and becomes a mere penalty with the characteristics of regulation and punishment.” *Dep’t of Rev. of Montana v. Kurth Ranch*, 511 U.S. 767, 779 (1994) (quoting *A. Magnano Co. v. Hamilton*, 292 U.S. 40, 46 (1934)).<sup>3</sup> The Supreme Court certainly would not have upheld the

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<sup>3</sup> The Supreme Court’s statement in a footnote in *Bob Jones University v. Simon*, 416 U.S. 725, 741 n.12 (1974) that it had “abandoned” “distinctions between regulatory and revenue-raising taxes” such as those drawn in *Hill v. Wallace* was

federal intrusions into traditional State domains at issue in *Lopez* and *Morrison* if Congress had simply imposed a “tax penalty” for gender-motivated violence or possession of a gun in a school zone. This Court need not reach that question, however, because Congress expressly imposed a direct regulatory mandate, instead of imposing only a tax on lawful conduct.

## **II. The ACA’s Dramatic Expansion of the Medicaid Program Is Not a Valid Exercise of Congress’s Spending Power.**

The government does not argue that the Commerce Clause or the taxing authority supports the ACA’s dramatic expansion of the States’ Medicaid burdens. Nor does it deny that the expansion would ordinarily violate the Tenth Amendment’s prohibition against commandeering state governments. Instead, the government resorts to the Spending Clause, arguing that the expansions are constitutional conditions on the States’ acceptance of federal funding.

Congress may not, however, employ its spending power to coerce States into capitulating to federal demands. *See Steward Machine*, 301 U.S. at 590; *Dole*, 483 U.S. at 211. The Supreme Court has thus “recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’” *Dole*, 482 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590). By conditioning *all* of the States’ billions of

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dictum that has been superseded by *Kurth Ranch*’s recognition of the continued viability of such distinctions.

dollars of federal Medicaid funding on their adoption of the ACA's expanded eligibility and coverage terms, Congress has plainly passed that point. No State could afford to turn down all of its Medicaid money, which accounts for 40% of all federal grant money, and there is no reasonable relationship between the changes Congress seeks to impose and the withholding of *all* Medicaid funds. Congress itself was so sure the States could not decline to continue participating in Medicaid that it provided no other way for the neediest individuals to comply with the individual mandate.

**A. The Supreme Court Has Repeatedly Reiterated that Spending Power Conditions Must Be Truly Voluntary.**

“No matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate.” *New York*, 505 U.S. at 178; *see also Printz*, 521 U.S. at 935. Thus, although the Supreme Court has “identified a variety of methods ... by which Congress may urge a State to adopt a legislative program consistent with federal interests,” Congress may not resort to “outright coercion” to achieve that result. *New York*, 505 U.S. at 166.

To ensure that Congress may not use its spending power to circumvent that limitation, the Supreme Court has admonished that when Congress conditions acceptance of Federal funds upon adoption of a federal regulatory program, the legitimacy of Congress's action “rests on whether the State *voluntarily* and

knowingly accepts the terms” Congress has attached to the funds. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) (emphasis added). Though a spending power condition is always in some superficial sense “voluntary” — Congress does not legally obligate States to accept federal funding — the Court has made clear that a State’s adoption of a federal regulation in exchange for federal funding must be voluntary “not merely in theory but in fact.” *Dole*, 483 U.S. at 211-12.

To that end, the Court has “recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’” *Id.* at 211 (citing *Steward Machine*, 301 U.S. at 590); accord *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999). Although the Court has acknowledged the difficulty inherent in determining “the point at which pressure turns into compulsion,” *Steward Machine*, 301 U.S. at 590, it has never abandoned the enterprise. *See id.* at 591 (“We do not fix the outermost line. Enough for present purposes that wherever the line may be, this statute is within it.”); *Dole*, 483 U.S. at 211 (reaffirming coercion doctrine’s existence before rejecting coercion claim on the merits); *Sabri v. United States*, 541 U.S. 600, 608 (2004) (similar). If the coercion here does not cross the line, then the Court was simply mistaken to identify any constitutional limit at all.

The contours of the coercion doctrine are best illustrated by the Fourth Circuit’s en banc plurality opinion in *Virginia Department of Education v. Riley*. There, the Federal government withheld all of a \$60 million grant under the Individuals with Disabilities Education Act (IDEA) after Virginia refused to provide services to a small number of individuals. *See* 106 F.3d 559, 562 (4th Cir. 1997). Although the court held that any requirement that those individuals be provided with services was not unambiguously set forth in the statute as required by *Dole*, *id.* at 567–68, a six-judge plurality went on to explain that there was also a “substantial” question whether the government’s actions rendered Congress’s exercise of its spending power impermissibly coercive, *id.* at 569.

Judge Luttig’s plurality opinion rejected the suggestion that courts are incapable of determining when the sheer enormity of a federal inducement makes it coercive, noting that “[t]he difference between a \$1000 grant and, as here, a \$60 million grant, insofar as their coercive potential is concerned, is self-evident.” *Id.* at 570. The plurality also pointed out that, “in stark contrast” to *Dole*, where South Dakota stood to lose only 5% of its funding if it rejected the condition in question (the critical factor in the Supreme Court’s analysis, *see Dole*, 483 U.S. at 211), the Federal government withheld *all* of Virginia’s IDEA funding, even though Virginia’s refusal to comply with the condition in question only affected a very small portion of students “for whom the special education funds were earmarked.”

*Riley*, 106 F.3d at 569. “This is a condition considerably more pernicious than the ‘relatively mild encouragement’ at issue in *Dole*.” *Id.* (quoting *Dole*, 483 U.S. at 211).

Since *Riley*, the Fourth Circuit has reiterated its view that “serious Tenth Amendment questions would be raised” if Congress disproportionately conditioned the entirety of a large federal grant upon a State’s adoption of limited revisions to a much broader program. *West Virginia v. U.S. Dep’t of Health & Human Servs.*, 289 F.3d 281, 291 (4th Cir. 2002) (rejecting coercion claim based on finding that government had *not* withheld or threatened to withhold State’s entire Medicaid grant); *see also Jim C. v. United States*, 235 F.3d 1079, 1083 (8th Cir. 2000) (en banc) (Bowman, J., dissenting) (four-judge dissent concluding that Congress exceeded its Spending Clause powers because “the proportion of federal funds for education in Arkansas here placed at risk by the federal scheme (100%), the amount of those funds (some \$250,000,000), and the difficulty of making up for the loss of those funds if the State elects not to [accept the condition] all lead to the conclusion that pressure has turned into compulsion”).

Following in the footsteps of *Dole*, these decisions correctly recognize that the coercion doctrine focuses on both the size of the federal inducement and the relationship between the condition and the inducement. The more massive the amount of federal funding that Congress threatens to withhold, the greater the need

for Congress to demonstrate a reasonable relationship between the conditions and the funds, lest Congress simply manipulate its power of the purse to coerce States into capitulating to federal demands.

**B. Congress’s Conditioning of Billions of Dollars in Medicaid Funding on States’ Acceptance of the ACA’s Expansion of Medicaid Is Impermissibly Coercive.**

Whether Congress employed impermissible coercion in the ACA is not a close question; under any meaningful analysis, it did. The ACA seeks to significantly expand Medicaid eligibility and coverage. *See* pp. 6-8, *supra*. Yet rather than simply hold out the promise of *additional* funding should States agree to these expansions, Congress has threatened to withhold *all* Medicaid funding — literally billions of dollars for most States — if States do not accept Congress’s terms. That is unquestionably coercive, as States quite literally cannot afford to sacrifice billions in federal funds raised from the State’s own residents, and therefore have no real choice as to whether to accept these new conditions.

Medicaid is the single largest federal grant-in-aid program, accounting for a staggering 40% of *all* federal funds paid to States and approximately 7% of all federal spending. In 2008, the average State received well over \$1 billion in Medicaid funding; even the lowest recipient (Wyoming) received \$246 million. *Cf. Riley*, 106 F.3d at 570 (plurality opinion) (noting that “the coercive potential”

of a \$60 million grant “is self-evident”).<sup>4</sup> States spend, on average, 20% of their budgets on Medicaid expenditures, and federal funds cover at least half (oftentimes more) of each State’s costs. R.E. 1555. Florida, for example, currently devotes 26% of its entire state budget to Medicaid; if Florida lost federal funding, it would have to devote more than 60% of all state tax revenues to Medicaid in order to maintain existing, pre-ACA benefits. R.E. 493. Given the scale of that impact, States have no meaningful choice between doubling the percentage of state tax revenues dedicated to medical coverage and complying with additional strings attached to those pre-existing federal funds. The federal funds are themselves supplied by taxpayers in the State, so a State cannot simply take on the responsibility and increase State tax revenues accordingly. Although the precise impact of Medicaid funding differs from State to State, one thing is clear: the loss of *all* Medicaid funding would be devastating to any State. The federal government does not – and could not – deny this basic reality.

Yet that is precisely what the ACA threatens. The only discernable relationship between the size of the federal inducement and the conditions the ACA imposes is that the former leaves the States with no choice but to accept the latter. That is not a reasonable relationship; it is unadorned coercion.

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<sup>4</sup> State-by-State Medicaid data was most recently published in 2008, when federal spending totaled \$192 billion. R.E. 1551–55. Federal Medicaid spending increased by more than 30% (to \$251 billion) in 2009 and is predicted to increase by another \$434 billion before the decade is over. R.E. 1425.

That coercive effect was clear to Congress. The ACA's otherwise comprehensive scheme for universal health insurance provides no means *other than Medicaid* through which the Nation's neediest residents might comply with the mandate to maintain minimum health insurance coverage. *See* ACA § 5000A(f)(1)(A). By predicating the individual mandate and its coverage of the poorest citizens on the States' inability to withdraw from Medicaid, Congress recognized that States could not realistically turn down the massive federal funds at stake.

The constitutional violation is further illustrated by the fact that the ACA does not simply (or even primarily) impose conditions on how the States spend federal funds. The Act instead compels States to adopt, enforce, and even help fund a comprehensive federal regulatory program — something Congress could not otherwise do without running afoul of the Tenth Amendment commandeering doctrine, *see Printz*, 521 U.S. at 935. To be sure, Congress can and often does use its spending power to attempt to persuade States to adopt federal regulatory programs. But when Congress pools massive amounts of federal resources into a single lump sum that it threatens to withhold absent State capitulation, its actions can no longer be characterized as simple persuasion, but instead constitute “forbidden regulation in the guise of Spending Clause condition[s].” *Riley*, 106 F.3d at 569.

**C. Neither the District Court Nor the Government Provided Any Meaningful Response to the Merits of the States' Coercion Claim.**

In denying the government's motion to dismiss the States' coercion claim, the district court recognized that, "[i]f the Supreme Court meant what it said in *Dole* and *Steward Machine Co.* (and I must presume that it did), there is a line somewhere between mere pressure and impermissible coercion." R.E. 434. The court further recognized that, as shown by the facts detailed above, the States "are in an extremely difficult situation," and the presence of coercion "can perhaps be inferred by the fact that Congress does not really anticipate that the states will (or could) drop out of the Medicaid program." *Id.* At the summary judgment stage, however, the district court appeared to hold that the Supreme Court did not mean what it said, and that coercion is not a valid legal theory. R.E. 2011. In doing so, the court erroneously relied on a line of decisions from other circuits that largely pre-dates and conflicts with the Supreme Court's most recent pronouncements on the subject in *Dole* and other cases. R.E. 2011–13.

Before *Dole*, two circuits rejected the coercion doctrine after mistakenly reading *Steward Machine* to foreclose any argument that the sheer enormity of a federal inducement can render spending legislation coercive. *See Oklahoma v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981); *N.H. Dep't of Employment Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980). As noted above, and as the district

court appeared to acknowledge, the Supreme Court subsequently corrected that misreading of *Steward Machine* in *Dole*. *See Dole*, 483 U.S. at 211.

Nonetheless, three other circuits have since relied upon the reasoning of the earlier court of appeals' decisions to foreclose coercion claims. *See Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000); *Doe v. Nebraska*, 345 F.3d 593, 599 (8th Cir. 2003); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989). The district court relied heavily on the Ninth Circuit's decision in *Skinner*, in which Judge Reinhardt suggested, in *obiter dictum*, that coercion claims are nonjusticiable. In support of that suggestion, the Ninth Circuit first relied upon *Schweiker's* pre-*Dole* analysis, and then posited that the Supreme Court had implicitly deemed coercion claims nonjusticiable in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), which addressed the Tenth Amendment commandeering doctrine, not the Spending Clause. Citing *Garcia*, the Ninth Circuit theorized: "The purpose of the coercion test is to protect state sovereignty from federal incursions. If this sovereignty is adequately protected by the national political process [according to *Garcia*], we do not see any reason for asking the judiciary to settle questions of policy and politics that range beyond its normal expertise." *Skinner*, 884 F.2d at 448.

The Ninth Circuit's analysis is doubly flawed. First, the Supreme Court decided *Dole* two years *after* it decided *Garcia*. Second, to the extent *Garcia*

suggested State sovereignty claims are categorically nonjusticiable, the Court subsequently rejected that view in *New York* and *Printz*, both of which struck down duly enacted federal statutes as unconstitutional federal incursions on State sovereignty. See *New York*, 505 U.S. at 177; *Printz*, 521 U.S. at 935. Accordingly, *Skinner* and the other decisions that followed it are inconsistent with no fewer than three Supreme Court cases and provide no persuasive basis for viewing coercion claims with suspicion. Unless and until the Supreme Court abandons the coercion doctrine, courts are bound to apply it, and the district court erred by failing to do so.

Nor has there ever been a stronger coercion claim than the one here, as confirmed by the fact that all of the decisions that have rejected coercion claims on their merits are readily distinguishable. *Dole*, for example, rejected a coercion claim because Congress's attachment of a condition to 5% of federal highway funds (\$4 million) constituted only "relatively mild encouragement." *Dole*, 483 U.S. at 211. In *West Virginia*, the State failed to substantiate its allegation that the federal government "withh[e]ld (or threaten[ed] to withhold) the entirety" of its Medicaid funding. 289 F.3d at 292. And in *Steward Machine*, the State "d[id] not offer a suggestion that ... she was affected by duress." 301 U.S. at 589.

In rejecting the States' claim, the district court invoked purported "judicial findings" that Medicaid is a voluntary program. R.E. 2010. But the cases the court

cited only observed that States are under no legal obligation to participate in Medicaid; they did not address whether Congress had coerced their participation. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Fla. Ass'n of Rehab. Facilities v. Fla. Dep't of Health & Rehabilitative Servs.*, 225 F.3d 1208, 1211 (11th Cir. 2000); *Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998). Even if they had, those decisions would have little bearing on this case. The States' claim is that *the ACA* is impermissibly coercive because it conditions receipt of *all* Medicaid funds on the ACA's expansions of Medicaid. The validity of that claim can hardly be determined by reference to decisions that pre-date the ACA and its expansions by more than a decade.

Finally, the district court stated that there is a "factual dispute" about ACA's financial impact on the States that "cannot be resolved on summary judgment." R.E. 2009. If there were a material dispute of fact on the application of the coercion doctrine, that would only underscore the district court's legal error in holding that coercion claims are *per se* invalid.<sup>5</sup>

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<sup>5</sup> The district court stated that two States "acknowledged ... that they can withdraw from [Medicaid]." R.E. 2010. Those States acknowledged only that the ACA has not eliminated the theoretical possibility of withdrawal; both made clear that withdrawal is not an actual option. *See* R.E. 794 ¶16 ("Though theoretically possible, South Dakota cannot cease participation in the Medicaid Program."); R.E. 710 ¶2 (noting that "Nevada can still consider opting out of Medicaid" but withdrawal would be unaffordable).

Ironically, however, the government’s arguments help underscore the extent of the coercion. The government has argued, for example, that it will offer additional funding to States that capitulate to its demands. That renders the ACA more coercive, not less, as it increases the amount of funds States would forfeit — funds obtained largely through federal taxes on States’ residents — were they to reject Congress’s demands. Whatever “the point at which pressure turns into compulsion,” *Steward Machine*, 301 U.S. at 590, the ACA has far surpassed it.

### **III. The District Court Ordered Appropriate Relief.**

#### **A. The Individual Mandate and Medicaid Reforms May Not Be Severed from the ACA.**

The district court correctly held that the unconstitutional individual mandate is not severable from the rest of the ACA, and that the entire ACA must be invalidated. R.E. 2075. The same is true of the coercive Medicaid amendments for essentially the same reasons.<sup>6</sup> Thus, the unconstitutionality of *either* of those provisions is fatal to the entire ACA.

The government argues that the district court departed from settled legal standards by striking down the ACA in its entirety even though many of its provisions *could* operate in isolation, without the individual mandate. But the

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<sup>6</sup> The States also continue to maintain that the employer mandate and health exchange benefit provisions violate the Tenth Amendment. Although the district court dismissed those claims as foreclosed by Supreme Court precedent, R.E. 424–25, the States reserve their right to challenge the Supreme Court’s decisions in *Garcia* and *Hodel* before the Supreme Court.

“well established” severability doctrine does not turn on whether Congress *could* have passed the remainder of the same act without the unconstitutional provision; it instead asks whether Congress *would* have done so. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987).

Thus, whether constitutional provisions are capable of functioning without an unconstitutional one is not the only — or even primary — factor in the severance analysis. “The more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress.” *Id.* at 685. When “it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not,” the provisions may not be severed. *Buckley v. Valeo*, 424 U.S. 1, 108 (1976) (per curiam) (internal quotation marks and citation omitted); *see also Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010) (employing severance when “nothing in the statute’s text or historical context makes it ‘evident’ that Congress, faced with the limitations imposed by the Constitution, would have preferred no [act] at all to” severance of the unconstitutional provision) (citation omitted).

**1. The core health care reforms are not severable.**

The district court correctly concluded that “it is reasonably ‘evident’ ... that the individual mandate was an essential and indispensable part of the health reform

efforts, and that Congress did not believe other parts of the Act could (or it would want them to) survive independently.” R.E. 2075. The ACA consists of five central components. *See* Govt.’s Opening Br. 13–15. In addition to the individual mandate, the Act: (1) mandates the creation of health benefit exchanges to help individuals and small businesses pool their purchasing power to obtain lower cost insurance; (2) establishes employer mandates, penalties and incentives to expand the availability of employer-sponsored insurance; (3) expands Medicaid eligibility and coverage and offers tax credits to create affordable insurance options for those with incomes up to 400% of the poverty level; and (4) bars insurers from denying, canceling, capping, or increasing the cost of coverage based on an individual’s pre-existing conditions or coverage history.

As the government itself has emphasized, Congress intended each of these core components, including the Medicaid expansion, to “work[] in tandem” with the individual mandate to make insurance more available and affordable. R.E. 141. Indeed, when arguing that the individual mandate is constitutional, the government has repeatedly asserted that “Congress ... concluded that the minimum coverage provision is *necessary* to make the other regulations in the Act effective.” R.E. 143 (emphasis added); *see also* R.E. 999 (“the minimum coverage provision forms an integral part of the ACA’s larger reforms of health insurance industry

practices”).<sup>7</sup> As the district court observed, the government referred to the mandate “as an ‘essential’ part of the Act at least fourteen times in their motion to dismiss.” R.E. 2065. Thus, the government is in no position to assert that the mandate is severable.

The government’s concessions were unavoidable because Congress plainly intended the individual mandate to render the Act’s insurance reforms more affordable for the federal government, the States, and the insurance industry. As Congress found, “[b]y significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the [mandate], together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.” ACA § 1501(a)(2)(H). That makes the individual mandate the “lynchpin of the entire health reform effort.” R.E. 2068.

Conversely, the other reforms, including the Medicaid expansion, are necessary to make insurance available to individuals covered by the mandate. As the government has explained, many individuals covered by the mandate “are unable to obtain [insurance] without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion that the Act will provide.” R.E.

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<sup>7</sup> To be clear, the States by no means concede that the Act’s five core provisions achieve that or any other goal Congress set forth. But the relevant question in the severance analysis is how Congress *intended* the Act to function. See *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006).

984–85. Indeed, expanded Medicaid coverage is especially essential to the viability of the individual mandate, because under the ACA, Medicaid is the *only* way that the poorest of covered persons can comply with the mandate.

Accordingly, the government specifically conceded in the district court that “the guaranteed issue and community rating insurance industry reforms in Section 1201 will stand or fall with the minimum coverage provision” because they are not severable. R.E. 1765. There is no basis for suggesting that the mandate is severable from some but not all of the core, interrelated health insurance reforms — and the government is careful not to do so in this Court, and not to argue that Congress would have enacted any of the ACA’s core insurance reforms without the individual mandate. As the district court determined, the government’s broad concession that “the minimum coverage provision is *necessary* to make the other regulations in the Act effective,” R.E. 143 (emphasis added), is fatal to any effort to sever those regulations. R.E. 2069, 2074.

**2. The various other provisions of the Act are not severable.**

The government’s argument that some unidentifiable number of the Act’s other 450 provisions are severable, Govt.’s Opening Br. 57, misses the mark. As the district court explained, although the other individual tax provisions of the Act might have “no discernable connection to health care,” their inclusion was no accident; they “w[ere] intended to generate offsetting revenue” for the Act’s costly

central reforms. R.E. 2074. As the government aptly put it, “[w]hen Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions.” R.E. 1024.

Thus, while the government identifies a handful of provisions that on their face may appear to be unrelated to the Act’s core components, *see* Govt.’s Opening Br. 56–57, it ignores that Congress carefully calibrated each provision to ensure that the financial obligations the Act imposes are equivalent to the revenue and savings it generates. Extracting the individual mandate — the centerpiece — from the law would, of course, dramatically change its cost. But there would be no way to determine which offsetting provisions of the ACA Congress would have rewritten had the individual mandate not been included.

Moreover, once one recognizes that the central provisions of the ACA are not severable, it is wholly unrealistic to expect the district court to sort through the remaining 450 provisions to attempt to divine which Congress would have enacted independently. That is a wholly artificial exercise once the core of the bill is removed. And as the district court observed, “[g]oing through the 2,700-page Act line-by-line, invalidating dozens (or hundreds) of some sections while retaining dozens (or hundreds) of others, would not only take considerable time and extensive briefing, but it would, in the end, be tantamount to rewriting a statute....”

R.E. 2073–74. Even the government has not attempted to undertake that exercise — it has only proffered some examples of provisions it asserts to be severable. Because the government is essentially seeking to rescue Congress from the gamble it intentionally employed by crafting the entire ACA around a provision of questionable constitutionality, the district court correctly declined to “substitute the judicial for the legislative department of the government” by picking and choosing among the ACA’s various provisions. *Ayotte*, 546 U.S. at 330 (quoting *United States v. Reese*, 92 U.S. 214, 221 (1876)).<sup>8</sup>

The government’s remaining criticisms of the district court’s analysis are equally unfounded. It first accuses the court of attributing “unwarranted significance to the absence of a severability clause.” Govt.’s Opening Br. 58. The district court did no such thing. The court expressly recognized that “the absence of such a clause ... ‘does not raise a presumption against severability.’” R.E. 2068 (quoting *New York*, 505 U.S. at 186). What the court found significant was Congress’s *removal* of a severability clause from an earlier version of the bill — a

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<sup>8</sup> Washington State believes that one provision that is arguably different is ACA section 10221, which reauthorized and amended the Indian Health Care Improvement Act (IHCIA). The IHCIA pre-existed ACA, and section 10221 merely involved a reauthorization, which in turn had an independent legislative genesis in S. 1790. Most tellingly, Native Americans served by the IHCIA are exempted from the individual mandate by section 1501(b). But this only underscores the difficulty of assessing the severability of the ACA’s hundreds of other miscellaneous provisions which do not address their relationship to the individual mandate.

version that the House had passed. That consideration is well within the bounds of what the Supreme Court has recognized to be relevant evidence of congressional intent. R.E. 2068 (quoting *Russello v. United States*, 464 U.S. 16, 23–24 (1983)). In any event, that was but one factor in the district court’s severability analysis, which relied much more heavily on the court’s conclusion that the Act “cannot function as originally designed” without the “lynchpin of the entire health reform effort”: the individual mandate. R.E. 2074, 2068.

The government also identifies no error by noting that the district court’s severability ruling may “affect the rights and obligations of parties not before the Court.” Govt.’s Opening Br. 60. Severance is a remedy for *Congress’s* benefit, not the plaintiff’s. *See Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). To the extent there is any requirement that a plaintiff have standing to raise a severability argument, that requirement is satisfied so long as the plaintiff is burdened by *any* of the act’s remaining provisions. *Compare Printz*, 521 U.S. at 935 (declining to address severance where no remaining provisions affected plaintiffs), *with New York*, 505 U.S. at 186–87 (addressing severability where remaining provisions affected plaintiffs). The States plainly alleged injury in fact resulting from multiple provisions of the Act, including the individual mandate, the Medicaid expansions, and the employer mandates. Thus, the district court correctly reached and resolved the severability question.

**B. The District Court Correctly Included All Parties in its Judgment.**

The government concedes that at least one of the individual plaintiffs has standing to challenge the individual mandate, Govt.’s Opening Br. 6 n.1, and it does not dispute that the States have standing to challenge the expansion of Medicaid. Nonetheless, the government asserts that the district court erred in including the States within the scope of its declaratory relief concerning the individual mandate. It is well settled, however, that so long as at least one plaintiff has standing with respect to each claim, a court “need not consider whether the other ... plaintiffs have standing.” *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 264 n.9 (1977); accord *Massachusetts v. EPA*, 549 U.S. 497, 518 (2007); *Watt v. Energy Action Educ. Fund*, 454 U.S. 151, 160 (1981).

In any event, the States have standing to challenge the individual mandate for at least three separate and independent reasons. *First*, the mandate requires all individuals to maintain a minimum level of insurance, including individuals who are either newly eligible for Medicaid or were previously eligible but had opted not to enroll. As the government has recognized, the mandate will therefore require millions more individuals to enroll in Medicaid, imposing millions of dollars in additional costs on the States. Indeed, “[o]f the additional 34 million people who are estimated to be insured by 2019 as a result of the [individual mandate], a little more than one-half (18 million) would receive Medicaid coverage due to the

expansion of eligibility.” See Richard S. Foster, *Estimated Financial Effects of the “Patient Protection and Affordable Care Act,”* Centers for Medicare & Medicaid Servs., Apr. 22, 2010, at 6, available at [https://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf); R.E. 501 n.39.

That inevitability is not a product of “unfettered choices made by independent actors,” *ASARCO Inc. v. Kadish*, 490 U.S. 605, 615 (1989) (opinion of Kennedy, J.), but is a necessary and intended consequence of the ACA, which *requires* covered individuals to secure health insurance, and leaves Medicaid as the *only* option for numerous low-income individuals to comply. See ACA §§ 1501(b), 5000A(f)(1)(A). The States have therefore alleged a “concrete and particularized” injury that is “fairly traceable” to the individual mandate and redressed by the relief the district court granted. *Summers v. Earth Island Inst.*, 129 S. Ct. 1142, 1149 (2009); see also *Fla. State Conference of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1163 (11th Cir. 2008) (“probabilistic harm is enough injury in fact to confer standing”) (internal quotation marks and citation omitted).

*Second*, the States have standing because they have alleged that the individual mandate renders the entire Act invalid on non-severability grounds. The States have standing to raise that argument so long as they allege that any of the Act’s provisions causes them injury in fact, as such injury would be remedied by a declaration that the Act is invalid. See *Brock*, 480 U.S. at 684 (adjudicating claim

that entire statute was invalid as a result of unconstitutional legislative veto provision, where plaintiffs alleged injury based on other portions of the statute). The States have plainly demonstrated injury in fact caused by the Medicaid and employer mandate reforms, and therefore have standing to seek invalidation of the Act on the ground that the individual mandate is unconstitutional.

*Finally*, as the district court found, the States have standing to challenge the mandate as an impermissible incursion into their sovereign right to enact and enforce legislation mandating that their citizens may *not* be compelled to purchase insurance. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 601 (1982) (recognizing sovereign’s interest in its “power to create and enforce a legal code); *Alaska v. U.S. Dep’t of Transp.*, 868 F.2d 441, 443 n.1 (D.C. Cir. 1989) (“States’ sovereign interest in law enforcement is sufficient to support standing”). That theory of standing is not barred by *Massachusetts v. Mellon*, 262 U.S. 447 (1923), which held only that a State lacks standing when it demonstrates no “quasi sovereign rights actually invaded or threatened” by the statute in question. *Id.* at 485.

## CONCLUSION

For the foregoing reasons, the Court should affirm the judgment below invalidating the ACA in its entirety.

Respectfully submitted,

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## **CERTIFICATE OF COMPLIANCE**

Pursuant to Rule 32(a) of the Federal Rules of Appellate Procedure, I hereby certify that the textual portion of the foregoing brief (exclusive of the disclosure statement, tables of contents and authorities, certificates of service and compliance, but including footnotes) contains *16,276* words as determined by the word-counting feature of Microsoft Word 2000 *in 14-point Times New Roman*.

/s/ Paul D. Clement

May 4, 2011

## CERTIFICATE OF SERVICE

Pursuant to Rule 25 of the Federal Rules of Appellate Procedure, I hereby certify that I have this 4th day of May, 2011, served a copy of the foregoing documents, by agreement with opposing counsel, by electronic mail, and by U.S. on the following counsel:

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