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# Brief of Amici Curiae Jewish Alliance for Law, Social Action (JALSA), Jewish Council on Urban Affairs (JCUA), Jewish Social Policy Action Network (JSPAN), New England Jewish Labor Committee (JLC), and Professor Abigail R. Moncrieff in Support

Abigail Moncrieff
*Boston Univeristy School of Law*, arm11@bu.edu

Andrew Fischer

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# BRIEF OF *AMICI CURIAE* JEWISH ALLIANCE FOR LAW & SOCIAL ACTION (JALSA), JEWISH COUNCIL ON URBAN AFFAIRS (JCUA), JEWISH SOCIAL POLICY ACTION NETWORK (JSPAN), NEW ENGLAND JEWISH LABOR COMMITTEE (JLC), AND PROFESSOR ABIGAIL R. MONCRIEFF IN SUPPORT OF PETITIONERS ON THE INDIVIDUAL LIBERTY IMPLICATIONS OF THE MINIMUM COVERAGE PROVISION

**In Department of Health & Human Services v. State of Florida**

Boston University School of Law Working Paper No. 12-25
(May 22, 2012)

**Abigail Moncrieff**
Boston University School of Law

**Andrew Fischer**
Jason & Fischer

Zoë Sajor
Boston University School of Law – Student

Rachel Smit
Boston University School of Law – Student

Emily Westfall
Boston University School of Law -- Student

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No. 11-398

In The
# Supreme Court of the United States

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DEPARTMENT OF HEALTH
AND HUMAN SERVICES, *et al*.,

*Petitioners,*

v.

STATE OF FLORIDA, *et al*.,

*Respondents.*

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**On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit**

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## BRIEF OF *AMICI CURIAE* JEWISH ALLIANCE FOR LAW & SOCIAL ACTION (JALSA), JEWISH COUNCIL ON URBAN AFFAIRS (JCUA), JEWISH SOCIAL POLICY ACTION NETWORK (JSPAN), NEW ENGLAND JEWISH LABOR COMMITTEE (JLC), AND PROFESSOR ABIGAIL R. MONCRIEFF IN SUPPORT OF PETITIONERS ON THE INDIVIDUAL LIBERTY IMPLICATIONS OF THE MINIMUM COVERAGE PROVISION

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ANDREW M. FISCHER
(*Counsel of Record*)
JASON & FISCHER
47 Winter Street
Boston, MA 02108
telephone (617) 423-7904
fax (617) 451-3413
afischer@jasonandfischer.com

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## QUESTION PRESENTED

The minimum coverage provision does not require individuals to purchase any unique product or service but rather requires a standardized financial contribution to the national healthcare infrastructure from all legal residents who are able to pay – a kind of requirement that has never been found unduly or even unusually restrictive of individual liberty.

The question presented is whether the Eleventh Circuit erred in finding that the minimum coverage provision's implications for individual liberty support a holding of constitutional invalidity under the Commerce Clause and Necessary and Proper Clause.

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## INTEREST OF *AMICI CURIAE*[1]

The *amici* Jewish organizations represent a tradition of believing that the community has an essential role in providing for the sick. Preserving life and health is one of the highest of communal duties in the Jewish tradition, taking precedence even over the construction of a synagogue. These petitioners represent a minority community deeply committed to individual rights, including the right of privacy and the right of the individual to express choices of conscience in healthcare matters. Petitioners would oppose any sacrifice of genuinely fundamental individual rights in an effort to address the health care crisis.

The **Jewish Alliance for Law and Social Action (JALSA)** is a membership-based non-profit organization based in Boston working for social and economic justice, civil rights, and civil liberties for all peoples. Inspired by Jewish teachings and values, they have sought to achieve universal access and improvement of health outcomes through grassroots action, strategic coalition-building, and legislative initiatives. The organization was involved in the passage of the Massachusetts statute that served as a model for the Patient Protection and Affordable Care Act (ACA).

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[1] This brief is submitted with the consent of the parties, as lodged with the Clerk per the Docket Sheets. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party. *Amici* have borne their own expenses, without support from any party.

The **Jewish Council on Urban Affairs (JCUA)** combats poverty, racism and anti-Semitism in partnership with diverse communities in the Chicago area and beyond. Guided by prophetic Jewish principles, JCUA pursues social and economic justice for those who are most vulnerable by promoting a vision of empowering communities from within. Since its founding in 1964, JCUA has assisted groups in low-income communities and communities of color, built coalitions with diverse groups, advocated on issues of human rights, poverty and racism, and mobilized a Jewish constituency to create a more just world for all.

The **Jewish Social Policy Action Network (JSPAN)** is a non-profit organization working out of Philadelphia dedicated to protecting the constitutional and civil rights of minorities and the vulnerable. JSPAN utilizes education, testimony, *amicus curiae* briefs and permissible grassroots organizing to support the separation of church and state, to advance individual rights under law, and generally to pursue *tikkun olam*, the "repair of the world." JSPAN supports the availability of adequate healthcare, and health insurance in particular, to all Americans and has consistently supported the principles expressed in the ACA.

The **New England Jewish Labor Committee (JLC)** is the voice of the Jewish community in the labor movement and the voice of the labor movement in the Jewish community. By engaging the Jewish community in support of issues affecting working

people and the labor movement, the JLC enables the Jewish community and the trade union movement to work together on important issues of shared interest and concern, in pursuit of our shared commitment to economic and social justice. Access to universal, quality, affordable healthcare is seen as a critical social justice goal.

**Professor Abigail R. Moncrieff** is Peter Paul Career Development Professor and Associate Professor of Law at Boston University School of Law, and she proudly joins these civil rights and civil liberties organizations as an *amicus*. Professor Moncrieff teaches and writes in the fields of healthcare law, federalism, and constitutional law, and she has written extensively on the liberty implications of the minimum coverage provision as well as on the federalism implications of the ACA. Professor Moncrieff therefore has a strong professional interest in the outcome of this case, as well as a personal pecuniary interest in the continuing security of the healthcare infrastructure. She joins this brief together with her students, **Zoë Sajor**, **Rachel Smit**, and **Emily Westfall**, whom she thanks for their excellent research assistance. Professor Moncrieff's relevant scholarly works are available at http://papers.ssrn.com/sol3/cf_dev/AbsByAuth.cfm?per_id=784767.

## SUMMARY OF THE ARGUMENT

In its analysis of the minimum coverage provision, the Eleventh Circuit mischaracterized the statute's implications for individual liberty, both in terms of the provision's substantive intrusion on individual freedom and in terms of its structural incursion on state power to protect that freedom. As a result, the Court reached the wrong decision on the merits of the Article I challenge.

Although respondents do not argue that the so-called "individual mandate" violates any protectable rights, they do argue – and the Eleventh Circuit held – that the provision's implications for liberty support invalidation under the Commerce Clause and Necessary and Proper Clause. The Eleventh Circuit correctly noted that, under this Court's precedent, concerns about liberty often shape federalism doctrine. But the Court has emphasized such concerns only in a limited set of federalism cases: those in which the national government has exerted a kind of control that falls within the states' traditional police power.

The individual mandate is not such a law. Contrary to the Eleventh Circuit's assertions, the minimum coverage provision does not require individuals to purchase any particular product. It is, instead, merely a requirement for individual financial participation in the national healthcare infrastructure, much like a tax. The provision is thus a kind of regulatory control that does not, under this Court's precedent, raise rights-based concerns.

Furthermore, although the Patient Protection and Affordable Care Act (ACA) certainly increases the federal government's involvement in insurance regulation, the statute preserves significant state authority over both health insurance and healthcare. Beyond the federally-mandated financial contribution, individuals remain free to choose among many insurance products for structuring their healthcare payments and free to choose whatever courses of medical treatment they prefer, subject almost entirely to state rather than federal definition.

## ARGUMENT

### I. THE ELEVENTH CIRCUIT MISCHARACTERIZED THE MINIMUM COVERAGE PROVISION'S IMPLICATIONS FOR INDIVIDUAL LIBERTY.

In holding that the minimum coverage provision ("provision" or "individual mandate"), 26 U.S.C.A. § 5000A, of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (ACA),[2] is unconstitutional under Article I, see U.S. Const. art I., § 8, the Eleventh Circuit hinged its analysis on the provision's implications for individual liberty. See *Florida ex rel. Att'y Gen.* v. *U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1284, 1291-92

[2] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

(11th Cir. 2011) (noting at the outset that the "ultimate goal" of "structural constitutional limitations" is "the protection of individual liberty" and that the mandate's perceived intrusion on freedom "strikes at the very heart of whether Congress has acted within its enumerated power").

Although the Eleventh Circuit correctly noted that one purpose of our government's federal structure is to protect freedom, the majority opinion made a critical error that led it to the wrong result on the merits: It misunderstood the basic nature and function of the minimum coverage provision. When properly characterized as a requirement for individual financial contribution to the national healthcare infrastructure rather than as a requirement for individual purchase of a unique product or individual consumption of a given commodity, the provision poses neither a threat to liberty nor a threat to federalism.

As civil rights and civil liberties organizations dedicated to improving access to high quality healthcare, *amici* are interested in both the protection of liberty *from* government and the facilitation of liberty *through* government. The federal structure serves both purposes, and it is vital that all units of government – Congress, the Executive, and this Court alike – strike an appropriate balance between limiting intervention and respecting regulation. With the ACA, Congress wrote a well-balanced law that supports a high quality healthcare infrastructure without

unduly restricting states' or individuals' power to satisfy their needs and preferences.

### A. Although Liberty is a Legitimate Concern in Federalism Analysis, the Liberty Interests that Have Been Relevant in this Context Are Those that Relate to the Core Police Power of the States.

A general principle of individual freedom undoubtedly underlies our government's federal structure. In part, federalism serves simply to slow down regulatory decisionmaking, to make restrictive interventions harder to pass. More importantly, though, federalism serves to place the most intrusive forms of regulatory power into the hands of smaller governments so that individuals are better represented in the regulatory processes that lead to their forfeitures of freedom, particularly their imprisonment. See *Bond* v. *United States*, 131 S. Ct. 2355, 2364 (2011) (noting that state governments allow individuals to make their voices heard "without having to rely solely upon the political processes that control a remote central power").

In keeping with the latter point, this Court has stressed the importance of federalism to liberty only when the national government has exerted a kind of control that belongs with the states' police power: regulations related to education, public health, and public safety. Indeed, all Supreme Court cases that have noted the interrelationship of liberty and

federalism have involved federal attempts to regulate public safety. See *Bond*, 131 S. Ct. 2355 (criminal chemical weapons ban); *United States* v. *Morrison*, 529 U.S. 598 (2000) (private right of action for victims of domestic violence); *Printz* v. *United States*, 521 U.S. 898 (1997) (background checks for gun sales); *United States* v. *Lopez*, 514 U.S. 549 (1995) (criminal prohibition on firearm possession near schools); *New York* v. *United States*, 505 U.S. 144 (1992) (regulation of nuclear waste disposal); see also *Gregory* v. *Ashcroft*, 501 U.S. 452 (1991) (interpreting a federal statute to preserve a state public health regulation: a mandatory retirement age for state judges).

By contrast, this Court does not emphasize libertarian[3] implications in federalism cases that center on purely financial regulations, such as taxes or other kinds of mandatory contributions, even when those financial regulations intend to affect individual behavior. In *South Dakota* v. *Dole*, 483 U.S. 203, 211-12 (1987), for example, the Court confronted the view that the federal government's effective taxation of states for refusing to change the drinking age raised concerns about state freedom, and it squarely rejected the argument. The Court noted that constitutional limits have always relied on "'a robust common sense which assumes the freedom of the will [to reject mere

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[3] Throughout this brief, we use "libertarian" in its small-l sense, to mean "related to liberty." We do not mean to refer to the Libertarian Party or to the broader political movement that has now come to be associated with the Tea Party.

financial incentives] as a working hypothesis.'" *Id.* (quoting *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 590 (1937)).

In short, the virtues of the states as subunits of government, providing citizens with greater opportunities of voice, diversity, and exit than they have at the national level, are important to individual freedom when the regulation at issue is truly coercive – when it is one that has historically fallen within the states' police power. Financial regulations are capable of raising the same kinds of libertarian concerns only if they reach a magnitude of intervention at which "'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach.*, 301 U.S. at 590). But universal obligations for financial participation that are well-calibrated and minimally intrusive, like ordinary taxes, have never been thought to raise libertarian concerns or to require state control. The Eleventh Circuit's apparent holding to the contrary constitutes a dramatic departure from this Court's longstanding and consistent precedent.

### B. The Minimum Coverage Provision is a Well-Calibrated and Non-Coercive Requirement for Financial Participation in the National Healthcare Infrastructure, Which Does Not Implicate State Police Power.

Given the role that liberty has played in federalism cases, the respondents would need to establish that the minimum coverage provision either is

non-financial or is truly coercive in order to establish that libertarian concerns can justify their narrow reading of Article I. But the mandate is, in fact, purely financial and not at all coercive.

Notwithstanding the Eleventh Circuit's and the respondents' insistence to the contrary, the individual mandate does not require individuals to buy any particular product or service. Instead, it merely requires legal residents of the United States to contribute some money to the national healthcare infrastructure, *either* by paying into a private insurance pool of the individual's choice *or* by making an equivalent or lesser "shared responsibility payment" to the national treasury. 26 U.S.C.A. § 5000A(b); § 5000A(c)(1) (capping possible penalties at the cost of an average private plan). Importantly, the maximum amount that the mandate requires any individual to pay is the average cost of the least-comprehensive level of private insurance coverage, § 5000A(c)(1)(B), meaning that individuals are not financially penalized for choosing to give their money to the federal fisc instead of giving it to private insurance. The only thing that self-insured individuals forfeit by choosing a shared responsibility payment over an insurance contract is the private insurance coverage, but that forfeiture is not a penalty at all for individuals like the respondents, who prefer to remain self-insured, see *Florida ex rel. Bondi* v. *U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1270-71 (N.D. Fla. 2011) (describing the allegations of two plaintiffs who claim to prefer self-insurance), aff'd in part,

rev'd in part *sub nom*. *Florida,* 648 F.3d 1235. Given the magnitude of the penalty and its statutory calibration to private insurance premiums, the minimum coverage provision requires nothing more or less than a universal, standardized contribution to the healthcare infrastructure from all legal residents who are able to pay.[4]

In this sense, the individual mandate is, as far as its effect on liberty is concerned, indistinguishable from an ordinary tax.[5] Although the mandate functions slightly differently from ordinary taxes – as we will discuss shortly – its effects on individual liberty are fundamentally the same. Indeed, Congress was aware that the mandate resembles a tax for liberty purposes; the provision contains a religious exemption that simply cross-references the Internal

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[4] The mandate excuses from this financial contribution legal residents who have public healthcare through the Military Health System (TRICARE) and Veterans Affairs. See 26 U.S.C.A. § 5000A(f)(1)(A)(iv)-(v). Those individuals, though, have earned their public benefit through their service and have supported the national infrastructure in other ways. Others are excused from the contribution only if they are unable to pay, like Medicaid enrollees, § 5000A(f)(1)(A)(ii), if they have paid into the system through prior taxation, like Medicare enrollees, § 5000A(f)(1)(A)(i), or if they fall into limited statutory exemptions, § 5000A(e).

[5] This brief does not argue that the individual mandate is a tax for purposes of the Anti-Injunction Act or the Article I taxing power. The point here is only that the mandate's imposition on liberty is no greater or lesser than that of a standard tax, which would be true even if the mandate constituted a commercial regulation rather than a tax.

Revenue Code's general religious exemption for self-employed individuals. 26 U.S.C.A. § 5000A(d)(2) (cross-referencing 26 U.S.C.A. § 1402(g)(1)). The religious exemption, thus, relates only to financial contribution, not to enrollment in health insurance, because financial contribution is all that the mandate ultimately requires.

The federal government compels residents to contribute to countless national infrastructures on which they might or might not individually rely, including the military, highway, telecommunications, ecological, agricultural, and energy infrastructures, among many others, and the individual mandate simply adds the healthcare infrastructure to that list. Cf. *Thomas More Law Ctr.* v. *Obama*, 651 F.3d 529, 564 (6th Cir. 2011) (Sutton, J., concurring) (noting that the mandate is no more intrusive than the many tax laws requiring individuals to "spend money on things they may not need"), petition for *cert.* pending, No.11-117 (filed July 26, 2011).

Of course, there is an obvious arguable distinction between the individual mandate and ordinary taxation (at least as taxation is commonly perceived): The minimum coverage provision relies on private entities to maintain the healthcare infrastructure rather than relying on public entities like the United States military. It is this difference more than any other that seemingly motivated the Eleventh Circuit to decry the individual mandate as a "novel" attempt to "compel" individuals "to enter the stream of commerce." See *Florida*, 648 F.3d at 1291-92

("Individuals subjected to this economic mandate have not made a voluntary choice to enter the stream of commerce, but instead are having that choice imposed upon them by the federal government."); *id.* at 1328 ("This economic mandate represents a wholly novel and potentially unbounded assertion of congressional authority: the ability to compel Americans to buy an expensive health insurance product they have elected not to buy. . . .").

But this arguable distinction is a false one. Many of our most important national infrastructures rely on private contractors for their primary support. Private utility companies are responsible for many states' energy infrastructures; private construction contractors maintain the highway and transportation infrastructures; private telephone and internet providers own the telecommunications infrastructure; private environmental consultants safeguard the ecological infrastructure; private farmers own the agricultural infrastructure. And even the military sometimes relies on private contractors to support its efforts, as the public learned in the Blackwater Security scandal, see Associated Press, *U.S. Embassy Resumes Use of Blackwater Security*, U.S.A. Today, Sept. 21, 2007. See generally Gillian E. Metzger, *Privatization as Delegation*, 103 Colum. L. Rev. 1367 (2003) (discussing governmental reliance on private contractors and its implications for structural constitutional limits). General tax dollars, collected compulsorily from all Americans, support these private companies without raising liberty-based constitutional

concerns – without provoking accusations that these programs force unwilling Americans "to enter the stream of commerce." *Florida*, 648 F.3d at 1292.

Importantly, the federal Medicare program also relies on private insurance companies, called "Medicare Administrative Contractors," to manage the part of the healthcare infrastructure that serves the elderly and disabled populations. See Ctrs. for Medicare & Medicaid Servs., *Part A/Part B Medicare Administrative Contractor* (Sept. 21, 2011). Under Medicare, the government forcibly collects tax dollars from all individuals working in the United States and uses those dollars to pay private health insurance companies to administer enrollees' benefits. This point might help to explain why a protester infamously commanded Representative Robert Inglis to "keep your government hands off my Medicare," Phillip Rucker, *Sen. DeMint of S.C. Is Voice of Opposition to Health-Care Reform*, Wash. Post, July 28, 2009, at A1 ("At a recent town-hall meeting in suburban Simpsonville[, S.C.], a man stood up and told Rep. Robert Inglis (R-S.C.) to 'keep your government hands off my Medicare.' "), but it raises the question of why such protesters do not, either when paying Medicare payroll taxes or when enrolling in the mandatory Medicare Part A program for hospitalization benefits, complain that they are being forced to "enter the stream of commerce." *Florida*, 648 F.3d at 1292.

The difference might be that, when paying Medicare taxes, the money goes first to the federal

government and only later to the Medicare Administrative Contractor, making the Medicare payments more obviously taxation. The minimum coverage provision, by contrast, cuts out the middle man of the federal government for those individuals who choose private insurance contracts over shared responsibility payments, effectively enlisting a network of private contracts *as* a public program. But that strategy for a public infrastructure is far from novel.

Even during the height of the *Lochner* era, see *Lochner* v. *New York*, 198 U.S. 45 (1905), this Court recognized that some private industries were so "impressed with a public interest" that they were essentially public in nature – sufficiently so that they could be rate-regulated despite the then-robust freedom of contract doctrine. *Adkins* v. *Children's Hosp. of D.C.*, 261 U.S. 525, 546 (1923) (citing *Munn* v. *Illinois*, 94 U.S. 113 (1876)), overruled in part by *West Coast Hotel Co.* v. *Parrish*, 300 U.S. 379 (1937). The paradigmatic example of such quasi-public entities is the common carrier – railroads, airlines, and the like – but the public interest exception to the freedom of contract also extended to bakers, warehouses, innkeepers, and many others. See *Munn*, 94 U.S. at 125 ("[I]t has been customary in England from time immemorial, and in this country from its first colonization, to regulate ferries, common carriers, hackmen, bakers, millers, wharfingers, innkeepers, &c., and in so doing to fix a maximum of charge to be made for services rendered, accommodations furnished, and articles sold.").

Crucially for present purposes, the same exception applied to insurers. See *O'Gorman & Young, Inc.* v. *Hartford Fire Ins. Co.*, 282 U.S. 251, 257 (1931) (holding that "[t]he business of insurance is so far affected with a public interest that the State may regulate the rates" (citing *German Alliance Ins. Co.* v. *Kansas*, 233 U.S. 389 (1914))). In fact, the *Lochner*-era Supreme Court explicitly analogized private insurance to taxation, reasoning:

> The effect of insurance – indeed, it has been said to be its fundamental object – is to distribute the loss over as wide an area as possible. In other words, the loss is spread over the country, the disaster to an individual is shared by many, the disaster to a community shared by other communities. . . . In assimilation of insurance to a tax, the companies have been said to be the mere machinery by which the inevitable losses by fire are distributed so as to fall as lightly as possible on the public at large, the body of the insured, not the companies, paying the tax.

*German Alliance*, 233 U.S. at 412-13. This Court thus has a long history of treating private insurance as a quasi-public infrastructure, closely analogous to a system of collective taxation, and the Court has therefore allowed insurance to be subject to intensive regulation even in the face of once-robust substantive restrictions.

Indeed, several states passed the first compulsory insurance provisions for workers' compensation

and automobile insurance during the same era. Perhaps because this Court had established that insurance was quasi-public, freedom of contract challenges to these provisions gained no traction. See *Alaska Packers Ass'n* v. *Indus. Accident Comm'n*, 294 U.S. 532, 541-43 (1935) (noting that a California court had characterized the state's workers' compensation regime as "compulsory insurance" but upholding the regime against a freedom of contract challenge on the ground that it merely assigned liabilities); see also *In re Opinion of the Justices*, 81 N.H. 566 (1925) (considering possible constitutional infirmities with a proposed compulsory auto insurance law in an advisory opinion to the New Hampshire legislature and raising only equal protection and dormant commerce clause issues, not freedom of contract issues). Even at the height of the *Lochner* era, then, compulsory insurance provisions did not raise libertarian concerns.

Of course, the *Lochner*-era Court's special treatment of insurance – and its analogizing of insurance to taxation – makes tremendous sense. Not only do insurance pools and tax funds play similar roles of risk-spreading and cost-sharing, but also, when free-riders and other market failures cause insurance pools to fail, taxpayers inevitably fill the gap. A property destroyed by fire that cannot be rebuilt must be condemned; a non-functioning automobile on the highway that cannot be towed must be cleared; and a family left behind after death that cannot self-sustain must be supported. Similarly, because we have decided as a matter of policy that all Americans with

emergent medical conditions must be treated, see Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, taxpayers frequently fill expensive gaps when the self-insured are unable to pay, see 42 U.S.C.A. § 18091(a)(2)(F) (finding that uncompensated care cost $43 billion in 2008). In the end, as the *Lochner* Court seemed to understand, requiring individuals to choose between paying into an insurance pool or contributing an equal or lesser sum to the national treasury does not actually change their baseline state of freedom. Taxpayers are already paying for systemic healthcare costs through the less-efficient public safety net.

The longstanding analogy between insurance and taxation also helps to refute the slippery slope arguments that have arisen in this litigation, including the District Court's fear that a finding of constitutionality might allow Congress to require purchases of anything from broccoli to automobiles. See *Florida*, 780 F. Supp. 2d at 1289. An important distinguishing feature of insurance is that it is *merely* a fiscal pool, available to protect against economic loss. Unlike a compelled purchase of broccoli or cars, a mandatory contribution to an insurance pool does not require the regulated individual to devote any of her time or space to keeping, selling, or destroying any physical object. The imposition on her liberty is thus extremely small and, again, purely financial. The appropriate analogy to food markets, then, is not to a broccoli mandate but rather to farm subsidies, which force all taxpayers to buy into the agricultural infrastructure

whether or not they consume the supported products. And those subsidies can be just as influential on consumption choices as the minimum coverage provision ever could be; the subsidies for domestic corn (combined with tariffs on imported sugar) have long "compel[led]," *Florida*, 648 F.3d at 1328, Americans to buy corn syrup instead of sugar. See Tim Worstall, *Big Corn's HFCS v. Big Sugar's Sucrose: Maybe Both Could Lose?*, Forbes.com (Dec. 26, 2011).

The Eleventh Circuit and the respondents posit a second distinction between the minimum coverage provision and other quasi-public infrastructures: Private individuals during the *Lochner* era were not required to give their money to the quasi-public entities, like insurance companies, *unless* they were likely to use or were in fact using the entities' services. Car insurance was obligatory only for drivers; workers' compensation funds were obligatory only for employers; and payments to common carriers, bakers, warehousemen, and grain elevators were obligatory only for users. The individual mandate, by contrast, applies to all legal residents of the United States, regardless of whether they are using or ever will use the healthcare system. See *Florida*, 648 F.3d at 1290-91.

The most that can be said of this distinction, though, is that it makes the ACA's statutory scheme slightly more analogous to mandatory taxation than the *Lochner*-era schemes were. There is simply nothing in this Court's constitutional jurisprudence or in the text of the Constitution itself that obligates

regulators to choose user fees over collective contributions to support public or quasi-public infrastructures. So long as the infrastructure in question is a proper subject of federal regulation and the magnitude of the compelled fee is reasonable, Congress may choose any regulatory approach it likes. Furthermore, it makes sense for Congress to choose collective contributions over user fees when all Americans are extremely likely to benefit from the supported infrastructure at some point and when payments are difficult to collect from users at the point of service. National defense is the classic example of an infrastructure with these characteristics, and healthcare is similar, particularly given individuals' failures to save sufficiently for needed care. See 42 U.S.C.A. §§ 18091(a)(2)(F)-(G) (finding that individuals consumed $43 billion of uncompensated care in 2008 and that such unsaved-for consumption contributes to 62 percent of personal bankruptcies).

In short, there is nothing in the least bit novel about relying on private insurance as a quasi-public infrastructure, nor is there anything novel about setting rates for and requiring contributions to private insurers in order to fund that infrastructure. This approach to collective maintenance of public goods has an established history in the United States, and it is a regulatory approach that has long been thought to respect even the most stringent

substantive libertarian constraints.[6] Furthermore, it is an approach that is, as this Court has long acknowledged, closely analogous to the standard *federal* function of distributing the costs of national public goods through taxation.[7]

Of course, the individual mandate has aroused considerable public backlash (further bolstering the analogy to taxation!) because many Americans are uncomfortable with the *perceived* requirement that they enter a private contract. Also, the mandate is obviously somewhat intrusive of individual freedom insofar as it directs Americans' use of their money.

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[6] This approach fell out of favor during the New Deal era, as the federal government began to replace quasi-public industry with purely public programs like Social Security. It is therefore understandable that the regulatory strategy appears novel to today's respondents. With the modern push towards privatization and deregulation, however, this approach to supporting public infrastructures might well become more common. The important point, though, is that quasi-public strategies for public infrastructures do not now raise nor have they ever raised implications for individual liberty beyond the generalized restraints that come with all taxation and regulation.

[7] Although the *Lochner*-era Supreme Court treated insurance as a local business that could not be subject to national regulation, see *Paul* v. *Virginia*, 75 U.S. (8 Wall.) 168 (1869), the Court has since reversed that holding, see *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944). It is now well established that the business of insurance crosses state lines and therefore falls within Congress's authority to regulate interstate commerce. Indeed, the respondents do not allege that Congress lacks authority to regulate health insurers directly; they have not challenged the many insurance regulations in the ACA.

But "[n]ot every intrusive law is an unconstitutionally intrusive law." *Thomas More*, 651 F.3d at 565 (Sutton, J., concurring). The individual mandate presents no greater threat to liberty than any ordinary requirement to pay for the support of our nation's infrastructures.

### C. The Minimum Coverage Provision Fully Respects and Preserves Individuals' Healthcare Autonomy.

One true distinction between the individual mandate and other quasi-public infrastructures is that the minimum coverage provision regulates health, which is a regime that has been dedicated to states' police power, see *Florida*, 648 F.3d at 1306, as well as a regime that has received special solicitude in modern substantive due process jurisprudence, see Abigail R. Moncrieff, *The Freedom of Health*, 159 U. Pa. L. Rev. 2209 (2011). Ultimately, however, this distinction makes no difference. The mandate does not attempt to influence public health regulation (the subject that has been state or local) or medical decisionmaking (the subject that receives heightened substantive protection). The mandate regulates only healthcare *financing*.

In the mythology that has arisen around this case, many commentators have analogized the minimum coverage provision to a requirement that individuals buy broccoli, see generally Einer Elhauge, Op-Ed., *The Broccoli Test*, N.Y. Times, Nov. 15, 2011,

at A35 (noting the prevalence of the broccoli analogy); Einer Elhauge, *The Irrelevance of the Broccoli Argument Against the Individual Mandate*, 366 New Eng. J. Med. e1 (2012) (arguing that the analogy ultimately fails), while others, including the District Court below, have also analogized the mandate to a requirement that individuals *eat* broccoli, *Florida*, 780 F. Supp. 2d at 1289. As discussed above, it is not at all clear that the provision compels any purchase at all because individuals can comply by making an equal or lesser financial contribution to government; and even if the provision did require a purchase, the analogy to broccoli would fail because the mandate includes no obligation to take ownership or possession of a physical object. Regardless, though, it is beyond cavil that the mandate does *not* require *consumption* of any particular medical care. In other words, the mandate does not, in fact, require anyone to eat his broccoli. The minimum coverage provision, at most, requires individuals to be insured against certain kinds of sickness and accidents. It does not require individuals to seek healthcare when they become sick or have an accident.

The individual mandate, therefore, does nothing to regulate individuals' autonomous medical decisions nor anything to regulate public health inputs or outcomes, nor does it in any way infringe on an individual's freedom to reject unwanted medical interventions. Cf. *Washington* v. *Harper*, 494 U.S. 210, 221-22 (1990) (noting that individuals have "a significant liberty interest . . . under the Due Process

Clause of the Fourteenth Amendment" in rejecting unwanted medical intervention). The provision is simply a requirement that all capable individuals contribute financially to the nation's healthcare infrastructure.

Again, the appropriate analogy to food markets is not to a purchase mandate for broccoli but rather to the mandatory contributions that all taxpayers make to the agricultural infrastructure through farm subsidies. Those subsidies flow from taxpayers to private farmers, not public programs; they are compulsory for all taxpaying residents; and although they alter the overall balance of the food supply (in favor of corn syrup over sugar, for example), the subsidies leave Americans free to choose what they eat. The only functional difference between the minimum coverage provision and farm subsidies is that the mandate channels financial support directly from taxpayers to private insurers instead of involving the national government as a middle man subsidizer. In the end, just as farm subsidies leave Americans free to eat whatever they choose, the insurance mandate leaves Americans free to pursue any course of medical treatment they choose.

It ought also to be relevant to healthcare autonomy that the individual mandate will *increase* many Americans' access to healthcare, improving rather than harming their freedom to obtain medical interventions. By mandating universal financial support for the healthcare infrastructure, the mandate ensures that high quality medical care will always be

available in the United States. In this sense, too, the mandate functions like farm subsidies, which have long been thought necessary to ensure that the food supply is sufficient to sustain Americans' freedom to access adequate nutrition. Because both food and healthcare are basic human needs, regulations that improve access to and quality of those goods (without restricting consumption choices) ought to be understood as fundamentally freedom-enhancing. Furthermore, because purchasing insurance coverage will constitute compliance with the mandate, many individuals will choose to gain easy financial access to healthcare by entering an insurance contract, rather than choosing to continue their reliance on often-faulty self-insurance by making a shared responsibility payment. Those individuals will gain significantly greater capacity to obtain healthcare, even though they will remain free to reject any healthcare they don't want. From the perspective of medical liberty and healthcare autonomy, thus, the individual mandate improves the baseline state of freedom for the currently insured and the currently uninsured alike.

## II. FOR THOSE WHO CHOOSE TO COMPLY BY PURCHASING INSURANCE, THE ACA LEAVES THE CONTENTS OF THEIR PURCHASE PRIMARILY TO STATE CONTROL, PRESERVING STATE POWER OVER THE ASPECTS OF THE MANDATE THAT MATTER MOST TO LIBERTY.

Although the Eleventh Circuit correctly noted that both the insurance and healthcare industries fall "within the sphere of traditional state regulation," *Florida*, 648 F.3d at 1305, the majority opinion grossly exaggerated the minimum coverage provision's departure from that traditional baseline. Indeed, the opinion merely asserted, without citation or elaboration, "that the individual mandate supersedes a multitude of the states' policy choices in these key areas of traditional state concern." *Id.* at 1306.

Of course, the mandate itself does no such thing. Whether viewed as a standardized contribution to the healthcare infrastructure or as a purchase mandate for an insurance product, the individual mandate itself, 26 U.S.C.A. § 5000A(a), says nothing at all about the nature of the insurance at issue, much less about the nature of the medical care that such insurance will cover, cf. § 5000A(f) (defining "minimum essential coverage" broadly to include any legal, comprehensive health insurance product). It is instead the ACA's other insurance regulations, including the definition of "essential health benefits" found elsewhere in the statute, 42 U.S.C.A. § 18022, that regulate the insurance products one can buy in complying

with the mandate. But the respondents do not allege here or anywhere else that those insurance regulations exceed Congress's Article I powers. Indeed, under this Court's holding in *South-Eastern Underwriters*, 322 U.S. 533, Congress has clear authority to regulate the contents and practices of any insurance contract bought or sold in the United States. It is only the supposed additional requirement that legal residents *enter* such contracts that is in dispute here.

That said, the ACA's overall regulatory approach to health insurance and healthcare is, in one sense, relevant to the mandate's implications for individual liberty: The greater the range of options available to individuals and states for complying with the mandate, the less concerned this Court needs to be that the mandate represents a coercive exercise of a federal police power. Cf. *Florida*, 648 F.3d at 1309 (worrying that a finding of constitutional validity would "vest Congress with a general police power"). It is thus highly relevant that the ACA, notwithstanding the Eleventh Circuit's conclusory assertion to the contrary, preserves significant state authority over both insurance and care. Because states have authority to diversify in regulating the contents of insurance contracts, individuals could have essentially limitless options for compliance with the mandate.

State diversification is possible through two avenues. First, the ACA preserves state authority over the aspects of public health and healthcare regulation that historically have been delegated to states' police power – a point that cuts in favor of constitutionality

under the Necessary and Proper Clause, see *United States* v. *Comstock*, 130 S. Ct. 1949, 1958-61 (2010) (stressing the importance to Necessary and Proper Clause analysis of the statute's degree of departure from traditional areas of federal concern), and that eviscerates the Eleventh Circuit's fear of a national police power. Second, the ACA provides the states with many opportunities for asserting their citizens' interests through national political and administrative processes, providing additional prospects for interstate diversification through the ACA regulatory structure as well as providing further support for constitutionality under the Necessary and Proper Clause, see *id.* at 1962-63 (noting that a statute is more likely to be constitutional if it "accounts for state interests").

### A. The Minimum Coverage Provision Preserves the States' Historic Police Power in the Regimes that are Most Important to Individual Liberty.

The Eleventh Circuit correctly noted that healthcare and insurance regulation traditionally fall within the police power of the states. But not all statutes that relate to healthcare or insurance implicate that power, as should be apparent from the multitude of federal healthcare and health insurance regulations already on the books. See, *e.g.*, Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681 (1998) (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.); Health

Insurance Portability and Accountability Act, Pub. L. No. 104-191, 101 Stat. 1936, 1936 (1996) (codified as amended in 42 U.S.C.); Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.); Old-Age, Survivors, and Disability Insurance Act of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended in 42 U.S.C.) (establishing Medicare); Federal Food, Drug, and Cosmetic Act of 1938 (FDCA), Pub. L. No. 717, 52 Stat. 1040 (1938) (codified as amended in 21 U.S.C.). The states' police power, then, has been and ought to be limited to those exercises of regulatory power that truly coerce individuals. Although the ACA sets a federal floor for some insurance regulations, the statute preserves the nearly exclusive state authority over medical regulation (such as licensure, vaccination, and quarantine), and it preserves significant state authority over insurance regulation, including the core state power to license insurers.

#### 1. States retain their nearly exclusive authority over regulation of medicine.

Although it is well established that the power to regulate healthcare and public health traditionally rests with the states, that tradition does not encompass all regulations related to healthcare. The tradition historically covers only true medical regulation, such as licensure of doctors and hospitals, and true public health regulation, such as mandatory vaccination and quarantine. Indeed, the cases that the

Eleventh Circuit cited in asserting the police power over healthcare – and the cases in which this Court has emphasized that state power – relate to one of those two regulatory regimes. The relevant cases concern regulations that seek to ensure the safety and efficacy of medical interventions and regulations that seek to prevent the spread of disease. See *Florida*, 648 F.3d at 1305 (citing *Gonzales* v. *Oregon*, 546 U.S. 243 (2006) (safety and efficacy of physician-assisted suicide); *Hill* v. *Colorado*, 530 U.S. 703 (2000) (safety of abortion clinics); *Barnes* v. *Glenn Theatre, Inc.*, 501 U.S. 560 (1991) (clothing mandates for exotic dancers); *Head* v. *N.M. Bd. of Exam'rs in Optometry*, 374 U.S. 424 (1963) (safety of optometrists through licensure regulations); *Barsky* v. *Bd. of Regents*, 347 U.S. 442 (1954) (safety of physicians through licensure regulations); *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905) (mandatory vaccination)); *Florida*, 648 F.3d at 1306 (citing *Hillsborough Cnty.* v. *Automated Med. Labs., Inc.*, 471 U.S. 707 (1985) (safety of blood donation), as well as insurance cases not relevant in this subsection); see also *Oregon-Washington R.R. & Navigation* v. *Washington*, 270 U.S. 87, 93-96 (1926) (noting that state police power includes quarantine, notwithstanding impact on interstate commerce, unless Congress has exercised conflicting control by statute).

Both of those categories of power – both medical regulation and public health regulation – remain untouched under the ACA. The statute says nothing about disease control; it leaves the licensure of

hospitals, doctors, and other medical practitioners entirely to the states; and it does nothing to shift safety and quality regulations to the federal government beyond the shift accomplished long ago in the FDCA. Although the ACA does create a grant program to encourage state experimentation with alternative medical malpractice regimes, the states are free to refuse those grants. 42 U.S.C.A. § 280g-15. Overall, the ACA requires no change in state regulations of medical care.

The core police power over healthcare, thus, remains entirely intact. All of medical regulation remains as much in state hands as it was before the ACA. States therefore remain primarily in charge of an individual's freedom to obtain or to reject medical treatments – the aspects of healthcare regulation that potentially implicate modern substantive due process. See generally Moncrieff, *supra*. Once individuals buy insurance policies to comply with the federal mandate, their access to and interactions with medical care will be subject to state rather than federal oversight, just as they always have been. As a result, if an individual dislikes her state's medical regulatory regime, she will be free to move to a different state with a different approach, and she will also be free to appeal to her smaller state government for policy change. The benefits of federalism to *medical* freedom, thus, are entirely untouched by the ACA and its individual mandate.

**2. States retain significant authority over insurance regulation.**

The ACA obviously does more to regulate insurance than medical care, but the statute nevertheless preserves significant state authority over insurance practice. Indeed, the states retain primary authority to define the range of products available to their citizens for complying with the individual mandate.

Most importantly, the ACA does nothing to disrupt the longstanding state power over insurance licensure. See Christopher C. Jennings & Katherine J. Hayes, *Health Insurance Reform and the Tensions of Federalism*, 362 New Eng. J. Med. 2244, 2245 (2010) (noting that states will continue licensing insurers). Under the ACA, a state may refuse to allow any given insurance company to write and sell policies within its borders. The states thus possess – and retain after the ACA – an absolute power of exclusion that they can use to control the health insurance products available to their citizens. The ACA obviously imposes some new limits on the contents and practices of insurance policies, as we discuss below, but the states retain an important power to exclude from their markets any insurance company or product that the state or its citizens dislike. Moreover, after extensive state lobbying during the passage of the ACA, Congress opted not to repeal the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2006), which continues to exempt insurance from federal antitrust regulations. See Jonathan Dinan, *Shaping Health Reform: State Government Influence in the Patient*

*Protection and Affordable Care Act*, 41 Publius 395, 399, 412-13 (2011). Any state that chooses to do so, therefore, may create an insurance monopoly or oligopoly within its borders without fear of federal intervention.

Of course, the ACA includes a new requirement that licensed insurance products be available for purchase through "American Health Benefit Exchanges," 42 U.S.C.A. § 18031, but it leaves the states with tremendous flexibility in designing and governing those exchanges. See generally Jon Kingsdale & John Bertko, *Insurance Exchanges Under Health Reform: Six Design Issues for the States*, 29 Health Aff. 1158 (2010). Indeed, the most fundamental choices about exchange design are up to state discretion. States can choose among a state-specific exchange, a federal exchange, and a multi-state regional exchange, 42 U.S.C.A. §§ 18031(f), 18041(c); they may establish multiple exchanges within their borders, § 18031(f); and they may decide whether or not to allow large group insurers to sell policies through the exchange, § 18032(f)(2). In short, just as the range of products is left to states to determine through licensure, so too is the interface for consumer purchases left to the states to design through exchange governance. The ordinary American's experience of purchasing insurance to comply with the mandate can therefore be governed almost entirely by the states.

Furthermore, it is already clear that the states will diverge in their exchange designs. See generally National Conference of State Legislatures, *State*

*Actions to Implement Health Exchanges* (Nov. 2011). Some states' exchanges will be non-profit private entities; some will be public-private partnerships; some will be new states agencies; some will run through existing state agencies. *Id.* Some states' exchanges will work as "active purchasers" of insurance, buying large-group plans on behalf of exchange enrollees, while others will work as "open marketplaces," allowing any licensed insurer in the state to make its product available through the exchange. *Id.* The ACA thus allows for interstate diversity and experimentation in the insurance marketplace, providing each citizen with an exit opportunity if she dislikes her state's insurance options or exchange interface. In short, the ACA leaves significant power over health insurance regulation in the hands of the smaller subunits of government, allowing citizens to retain a strong voice in insurance regulation "without having to rely solely upon the political processes that control a remote central power." *Bond*, 131 S. Ct. at 2364.

Admittedly, the ACA sets a federal floor on the categories of benefits that must be included in many insurance contracts, see 42 U.S.C.A. § 300gg-6(a) (requiring individual and small-group plans to include the "essential health benefits package"); § 18011(a) (exempting grandfathered plans); § 18022(a) (defining the "essential health benefits package"), and it sets a federal ceiling on the administrative costs (including profits) that insurers are allowed to incur, see § 300gg-18(b) (setting a minimum medical-loss ratio

of 85% for large-group plans and 80% for individual and small-group plans, effectively allowing insurers to spend 15-20% of their intake on administration and profit). The ACA also establishes new federal bans on many once-common insurance practices, including caps on annual and lifetime benefits, § 300gg-11, exclusions for preexisting conditions, § 300gg-3, rescissions of plans for reasons other than fraud, § 300gg-12, refusals to issue or renew policies for individuals, §§ 300gg-1, 300gg-2, 300gg-4(a), and practices of medical underwriting based on factors other than age, tobacco use, and geography, §§ 300gg(a)(1), 300gg-4(b).

These insurance regulations, however, do not represent a presumptuous federal takeover of state police power. Instead, they represent the culmination of many years of state experimentation with insurance reform, which has been necessary to address market failures that allow too many sleights of hand by insurers at patients' expense. But many of the states' regulatory attempts have experienced limited success because insurance companies can leave the states that regulate them in favor of states with laxer regimes. See generally Conrad F. Meier, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States*, Council for Affordable Health Insurance *passim* (2005). In other words, the story has been a classic race to the bottom requiring some federal standardization. The ACA accomplishes that standardization while preserving state

flexibility to innovate and diversify above the federal floor. Furthermore, the ACA leaves the states with primary enforcement power for all of these regulations, see 42 U.S.C.A. § 300gg-22, allowing coercive regulatory power to remain primarily in state rather than federal hands.

In short, much of the states' core police power over insurance remains intact after the ACA, including the central power of licensure. The ACA puts very little coercive regulatory power in federal hands, and it preserves opportunities for interstate differentiation in insurance regulation. The ordinary American's experience in complying with the individual mandate, thus, will be colored largely by state rather than federal regulation, leaving citizens with many opportunities to influence their health insurance options without resort to the "remote central power" of the federal government. *Bond*, 131 S. Ct. at 2364.

### B. The ACA Provides States with Political and Administrative Avenues to Influence the ACA's Development and to Innovate Beyond the ACA.

Of course, while the "political processes that control a remote central power," *id.*, may be entirely inaccessible or frustratingly unresponsive from an individual voter's perspective, state governments are quite capable of penetrating and influencing those processes on their citizens' behalf. A federal statute that provides clear avenues for state participation in

the federal regulatory regime is therefore less implicative of a federal police power than a federal statute that occupies the regulatory space to the exclusion of the states. The ACA provides several such avenues, in two broad categories.

First and most obviously, the ACA provides for "state innovation waivers," 42 U.S.C.A. § 18052, empowering the Secretary of Health & Human Services ("Secretary") to excuse individual states from most of the ACA's regulatory requirements, as long as the state comes up with a different way to achieve comparable results. If the majority of a state's citizens strongly dislike the individual mandate, then, they are not reduced to lobbying Congress for repeal of the minimum coverage provision; they can also ask their state government to apply for a waiver, replacing the mandate with a more liberty-protective option for universal coverage. See generally Office of the Press Sec'y, *Fact Sheet: The Affordable Care Act: Supporting Innovation, Empowering States* (Feb. 28, 2011). A similar waiver scheme has allowed for interstate diversity in Medicaid programs, see Frank J. Thompson & Courtney Burke, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. Health Pol. Pol'y & L. 971 (2007), indicating that the Secretary's oversight does not stifle states' ability to represent their citizens' needs and preferences.

A second broad feature of the ACA is equally important but subtler: By placing primary enforcement power in states' hands, the ACA gives the states

tremendous leverage to influence the everyday administration of the ACA's regulatory scheme. See generally Gillian E. Metzger, *Administrative Law as the New Federalism*, 57 Duke L.J. 2023, 2076 (2008) (noting that "responsibility for program implementation and enforcement appears to enhance state influence over federal agency decisionmaking"). The point here is different from the point above that leaving enforcement with the states helps to preserve the core of their police power. Here, the idea is that preserving state enforcement power forces federal administrators to be responsive to state demands. This aspect of state leverage in the federal-state relationship has already manifested in a dramatic and surprising way; the Department of Health & Human Services recently announced that it will not promulgate federal regulations to define the benefits required under the broad categories of "essential health benefits" but will instead leave that task to the states. Robert Pear, *Health Care Law Will Let States Tailor Benefits*, N.Y. Times, Dec. 17, 2011, at A1.

Within the ACA's regulatory regime, then, the states will have many opportunities to shape healthcare and insurance regulation to their citizens' needs and preferences. The Eleventh Circuit's fear that the ACA "forecloses the States from experimenting and exercising their own judgment" is therefore entirely misplaced. *Florida*, 648 F.3d at 1305 (quoting *Lopez*, 514 U.S. at 583 (Kennedy, J., concurring)). Although the ACA channels some of that experimentation and judgment through federal administrative processes,

the states retain many opportunities to experiment and diversify on their citizens' behalf. Individuals with particular healthcare and health insurance needs, thus, will not need to appeal to the "remote central power," *Bond*, 131 S. Ct. at 2364, for accommodation; they will be able to accomplish anything they need through state action. In short, even if most individuals will comply with the mandate by purchasing a product, the nature and content of that product is left largely to state control.

* * *

Given the structure of the individual mandate as well as the structure of the ACA as a whole, the minimum coverage provision presents no threat to individual liberty nor to the states' authority to protect that liberty. The mandate is merely a standardized obligation for all able taxpayers to make a financial contribution to the national healthcare infrastructure. The provision is thus indistinguishable from an ordinary tax in terms of its imposition on liberty. Furthermore, for those Americans who choose to make their mandatory contribution to a private health insurer instead of making a shared responsibility payment to government, their experience of purchasing insurance will be shaped primarily by state rather than federal regulation. If citizens are unhappy with the perceived purchase mandate, they will have many opportunities to accomplish change through their state representatives, "without having to rely

solely upon the political processes that control a remote central power." *Bond*, 131 S. Ct. at 2364.

## CONCLUSION

For the foregoing reasons, we urge the Court to reverse the Eleventh Circuit and direct entry of judgment for the petitioners on the constitutional validity of the minimum coverage provision.

Respectfully submitted,

ANDREW M. FISCHER

*Counsel of Record for the Amici Curiae*
JASON & FISCHER
47 Winter Street
Boston, MA 02108