No. 11-398

In the Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
PETITIONERS

v.

STATE OF FLORIDA, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF OF THE AMERICAN LEGISLATIVE EXCHANGE COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

(Minimum Coverage Provision)

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INTEREST OF *AMICUS CURIAE*[1]

The American Legislative Exchange Council ("ALEC") is the Nation's largest nonpartisan, individual-membership association of state legislators. ALEC has approximately 2,000 members—nearly one-third of all state legislators in the United States. It serves to advance Jeffersonian principles of individual liberty, free and efficient markets, responsible and accountable government, and federalism. ALEC has a number of interests in this litigation, reflected in its official activities, policies, and publications.

The Patient Protection and Affordable Care Act of 2010 ("the ACA" or "the Act") is an extraordinary law, founded on an expansive conception of federal legislative authority that is without precedent in our Nation's history, and fundamentally incompatible with the principles of limited government held by ALEC and its members. The ACA's individual mandate, which requires that virtually all individuals living in the United States purchase and maintain health insurance meeting federal specifications, is based on a sweeping view of federal legislative authority tantamount to the general police power the Tenth Amendment to the Constitution has long reserved to the States. See *Reina* v. *United States*, 364 U.S. 507, 510-511 (1960). ALEC and its members believe that such a theory of congressional authority is incom-

[1] No counsel for a party authored this brief in whole or part, and no counsel or party made a monetary contribution to fund the preparation or submission of this brief. No person other than the *amicus curiae* and its counsel made any monetary contribution to its preparation and submission. The parties have consented to this filing.

patible with the Constitution's enumeration of federal powers, and will have profound effects on the relationship between the federal Government and the States.

In 2008, ALEC developed influential model legislation, the Freedom of Choice in Health Care Act, that brought national attention to State-level opposition to the Administration's health reform agenda.[2] The model act served as the basis for legislation that was found to give the Commonwealth of Virginia standing in *Virginia ex rel. Cuccinelli* v. *Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010), *vacated*, 656 F.3d 253 (4th Cir. 2011), the first-in-the-nation challenge to the ACA.

The ACA's individual mandate is incompatible with ALEC's State-level efforts to reform health care and secure broader coverage through market-driven, cost-effective measures that preserve individual liberty and State sovereignty. For instance, ALEC's High Risk Health Insurance Pool Model Act (2007) is designed to make affordable health insurance coverage available for individuals with preexisting conditions and the medically uninsurable, through a state- and industry-funded high-risk pool. To date, 35 states have created high-risk pools guaranteeing universal access to health insurance without mandates or market-distorting price controls.

ALEC's efforts predate passage of the ACA: it has long supported market-based solutions to the rising

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[2] See, *e.g.*, Monica Davey, *Health Care Overhaul and Mandatory Coverage Stir States' Rights Claims*, N.Y. Times, Sept. 28, 2009, http://www.nytimes.com/2009/09/29/us/29states.html (discussing ALEC model legislation).

costs of health coverage, which numerous states have adopted in varying forms. These efforts are called into question—if not directly displaced by—the ACA's homogenizing federal mandate. ALEC's model Health Care Choice Act for States (2007), for instance, would allow individuals to purchase quality, affordable health insurance across state lines, in contrast to current policy, which restricts individuals to coverage sold within their State, constraining choices and increasing costs. And ALEC's model Mandated Benefits Review Act (2002) helps keep health coverage affordable by providing an institutional check on mandated health insurance benefits (*i.e.*, benefits individuals are required to "purchase" if they want to buy health coverage at all).

As the Court of Appeals noted, ALEC "filed a helpful *amicus* brief" with that court, "documenting the diverse array of policies implemented by states to provide their citizens with health coverage." Pet. App. 142a-143a n.124.

SUMMARY OF ARGUMENT

The Respondents persuasively demonstrate that the ACA's individual mandate exceeds Congress's authority under the Commerce Clause and the Necessary and Proper Clause; that the District Court correctly concluded that the individual mandate is not severable; and that (as argued by the States) the ACA's expansion of Medicaid exceeds Congress's Spending Clause authority. We do not attempt to repeat the full constitutional analysis set forth in those briefs.

Rather, as *amicus curiae*, ALEC undertakes the more limited task of demonstrating that the ACA's

individual mandate—and the expansive theory of federal legislative authority the Government has developed to defend it—are inconsistent with core constitutional principles of federalism that constrain the scope of the Commerce and Necessary and Proper Clauses. Contrary to the claims of some of petitioners' *amici* that this case does not involve "'the proper division of authority between the Federal Government and the States,'" Br. of the States of Maryland *et al.* as *Amici Curiae* 2 ("Maryland Br.") (quoting *New York* v. *United States*, 505 U.S. 144, 149 (1992)), ALEC and its member legislators recognize that upholding the constitutionality of the individual mandate would have profound effects on the State-federal relationship. The individual mandate represents a high-water mark for the assertion of federal legislative authority, transgressing long-established boundaries between state and federal legislation, and disrupting an array of State-level legislative and regulatory initiatives. The ACA cannot be reconciled with the core values of "our federalism," which protects "each State's freedom to 'serve as a laboratory; and try novel social and economic experiments'" designed to "tailor local programs to local needs." *San Antonio Indep. Sch. Dist.* v. *Rodriguez*, 411 U.S. 1, 49-50 (1973) (quoting *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)); see also *United States* v. *Lopez*, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring).

Principles of federalism and enumerated powers lie at the core of this Court's modern Commerce Clause jurisprudence. Notwithstanding the expansion of congressional authority to accommodate the modern U.S. economy, this Court has consistently ar-

ticulated the need for definite boundaries on the Commerce power. Two longstanding principles are that the Commerce Clause must not be construed so broadly as to "'obliterate the distinction between what is national and what is local,'" *Lopez*, 514 U.S. at 557 (quoting *NLRB* v. *Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937)), and that the Constitution reserves to the States, and denies the federal Government, a general police power, *United States* v. *Morrison*, 529 U.S. 619 n.8 (2000) (quoting *New York* v. *United States*, 505 U.S. at 155). These constraints apply with particular force in areas where States have historically possessed primary regulatory authority.

Upholding the ACA's individual mandate would disregard these fundamental principles. At bottom, the Government claims authority to force individuals to participate not only in interstate commerce, but in local, *intra*state commerce, on the theory that individual abstention from purchasing health insurance (whether stemming from a conscious decision or simple inattention) negatively affects the market for health insurance as compared to when individuals uniformly purchase insurance under a federal mandate. The Government's theory of the Commerce power admits of no principled limit, as Congress could mandate activity that affects interstate commerce with respect to nearly every individual decision, amounting to a general federal police power. Moreover, regulation of public health and welfare has historically been understood as a core component of the sovereignty reserved to the States. See, *e.g.*, *Barnes* v. *Glen Theatre, Inc.*, 501 U.S. 560, 569 (1991) ("The traditional police power of the States is defined

as the authority to provide for the public health, safety, and morals . . . .").

Similar federalism principles constrain Congress's authority under the Necessary and Proper Clause. That Clause cannot sustain legislation that violates the Constitution's textual and structural protections for state sovereignty, because such laws are not "proper" but rather "usurpations" of authority. *Printz* v. *United States*, 521 U.S. 898, 923-924 (1997) (internal quotations and citation omitted). The ACA's individual mandate fails to "properly account[] for state interests," *United States* v. *Comstock*, 130 S. Ct. 1949, 1962 (2010), in a "core" area of State regulatory power—regulation to protect public health, *Sporhase* v. *Nebraska ex rel. Douglas*, 458 U.S. 941, 956 (1982)—as it vests no discretion in the States to avoid regulation in this area of traditional state authority; disrupts and homogenizes a range of ongoing State legislative efforts; and grants the federal Government a general police power.

The federal individual mandate will disrupt or displace an array of health reforms numerous states are currently undertaking. These initiatives include market-based, cost-effective solutions such as the creation by some 35 States of high-risk pools to provide insurance to individuals who are otherwise medically uninsurable. The federalism costs of the ACA are heightened by the fact that Congress's rush to legislative judgment interrupted this active and ongoing State-level dialogue. And it did so just as a critical mass of States has begun to develop legislation tailored to their particular circumstances, and before they had an adequate opportunity to operate in their intended role as "laboratories of democracy"

to develop programs that other States could emulate. Although some of petitioners' *amici* assert that State legislation cannot effectively address issues involving the health care market, those claims simply do not reflect the States' more recent experience, and their recent and ongoing successes in this area.

ARGUMENT

"[D]eeply ingrained in our constitutional history" is the proposition 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). That core principle has long informed this Court's efforts to delineate clear boundaries for Congress's authority under the Commerce and Necessary and Proper Clauses. ALEC agrees with, and does not attempt to replicate, the compelling constitutional analysis set forth in the briefs for the Respondents. Rather, ALEC focuses on the federalism implications of the Government's expansive theory of federal legislative authority, which transgresses longstanding limits on Congress's legislative authority and divests the States of their traditional role as policy innovators in an area of historic State authority and sovereignty.

I. THE INDIVIDUAL MANDATE EXCEEDS CONGRESS'S AUTHORITY UNDER THE COMMERCE CLAUSE, AS INFORMED BY CORE PRINCIPLES OF FEDERALISM

It is a telling fact that, in its sixty-three-page opening brief urging the constitutionality of the ACA, the Government makes not one mention of the word "federalism." See generally Br. of United States. The

ACA's minimum coverage provision runs counter to that fundamental principle, effectively displacing State authority in a domain long considered to be a central part of their general police power. Indeed, the Government's expansive reading of the Commerce Clause admits of no principled limit to what activities the federal Government can choose to regulate.

A. Core Principles Of Federalism Constrain Congress's Commerce Clause Authority, And Deny The Federal Government A General Police Power

This Court's modern Commerce Clause jurisprudence rests on an irreducible "first principle[]" of federalism: that the "enumerated powers" delegated to the federal Government by the Constitution are "'few and defined,'" while "'[t]hose which . . . remain in the State governments are numerous and indefinite.'" *Lopez*, 514 U.S. at 552 (quoting The Federalist No. 45, at 292-293 (James Madison) (Clinton Rossiter ed., 1961)). Congress exercises its Article I authorities "subject to the limitations contained in the Constitution," including the Tenth Amendment. *New York*, 505 U.S. at 155-156. "[T]he Constitution divides authority between federal and state governments for the protection of individuals. State sovereignty is not just an end in itself: Rather, federalism secures to citizens the liberties that derive from the diffusion of sovereign power." *Id.* at 181 (internal quotations and citation omitted); see also *Lopez*, 514 U.S. at 576 (Kennedy, J., concurring).

From its early efforts to reconcile core federalism principles with Congress's expanded role in regulating the Nation's modern, industrialized economy, this

Court expressed "the fear that [without principled boundaries on the Commerce power] 'there would be virtually no limit to the federal power and for all practical purposes we should have a completely centralized government.'" *Lopez*, 514 U.S. at 555 (quoting *A.L.A. Schechter Poultry Corp.* v. *United States*, 295 U.S. 495, 548 (1935)). Although the Court's precise doctrinal formulations have varied, one enduring guidepost is that the Commerce power "is subject to outer limits" and must be construed "'in the light of our dual system of government.'" *Lopez*, 514 U.S. at 557 (quoting *Jones & Laughlin Steel*, 301 U.S. at 37). The Clause must never be read to "'effectually obliterate the distinction between what is national and what is local and create a completely centralized government.'" *Id.*

In addition to regulating the channels and instrumentalities of interstate commerce, Congress may regulate activities that "substantially affect" interstate commerce. *Gonzales* v. *Raich*, 545 U.S. 1, 17 (2005). In defining the outer boundaries of this aspect of the Commerce power, this Court has shown particular solicitude for areas in which States historically have "'possess[ed] primary authority,'" including criminal law, education, family law, *Lopez*, 514 U.S. at 561 n.3 (quoting *Brecht* v. *Abrahamson*, 507 U.S. 619, 635 (1993)), and regulating "to protect the health of its citizens." *Sporhase*, 458 U.S. at 956. See generally *Lopez*, 514 U.S. at 580 (Kennedy, J., concurring) ("[Courts] must inquire whether the exercise of national power seeks to intrude upon an area of traditional state concern."); *Morrison*, 529 U.S. at 615-616.

When Congress attempts to legislate in such areas, it "displace[s] state policy choices" and affects the "sensitive relation[s]" between the federal Government and the States. *Lopez*, 514 U.S. at 561 n.3 (internal quotations and citation omitted). There is "no better" an example of a power historically reserved to the States than the general police power: "the Founders denied the National Government" a "'plenary police power'" and instead "reposed [it] in the States." *Morrison*, 529 U.S. at 618 (quoting *Lopez*, 514 U.S. at 566); see also *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring in judgment) ("Residual power, sometimes referred to (perhaps imperfectly) as the police power, belongs to the States and the States alone."). And, as this Court has explained in adjudicating a conflict between federal and state regulation of public health, "the structure and limitations of federalism[] . . . allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Gonzales* v. *Oregon*, 546 U.S. 243, 270 (2006) (internal quotations omitted).

Indeed, this Court has examined closely "the implications" of any particular theory of Commerce Clause authority for the relationship between the federal Government and the States. And it has emphatically rejected an interpretation under which Congress could regulate "any activity that it found was related to the economic productivity of individual citizens," as it was "difficult to perceive any limitation on [that conception of] federal power, even in areas . . . where States historically have been sovereign." *Lopez*, 514 U.S. at 564.

B. Upholding The Individual Mandate As A Valid Exercise Of The Commerce Power Would Upset The Federal-State Balance And Effectively Grant Congress A Plenary Police Power

The core principles of federalism that have informed Commerce Clause jurisprudence are incompatible with the expansive reading of the Commerce power necessary to sustain the ACA's individual mandate. The Government initially contends that the mandate is an appropriate exercise of the Commerce power because it regulates "the way in which individuals finance their participation in the health care market"—in particular, the participation of "[i]ndividuals without insurance." Br. of United States 18. But the ACA does not regulate the practice of obtaining health care services without insurance; rather, it mandates the purchase of insurance, regardless of whether, when, or how an individual eventually obtains health care services.

The Government falls back on the argument that the individual mandate is "essential" to offset the negative economic effects on the insurance market that will otherwise result from the Act's guaranteed-issue and community-rating reforms. Br. of United States 27. Under this theory, the Government contends, an individual's inaction in failing to purchase insurance "substantially affects" interstate commerce. *Id.* at 23-27. This conception of the "substantially affects" test is not only without precedent in U.S. law, but creates grave federalism concerns by conferring a plenary police power on the federal Government.

Under the "substantially affects" test, the Court has upheld Congress's authority to restrict purely intrastate activity that has undesirable effects on interstate commerce, such as growing wheat, or cultivating marijuana, for private use. See *Wickard* v. *Filburn*, 317 U.S. 111, 125 (1942); *Raich*, 545 U.S. at 17-18. And the Court has upheld under that test Congress's authority to remove burdens or obstructions to interstate commerce. See *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 241, 252-258 (1964). Nonetheless, the Court has counseled caution in applying the "substantially affects" test, in recognition that its ready application could obliterate the distinction between what is local and what is national. *Lopez*, 514 U.S. at 559, 567. At bottom, the Court has applied this test only to activity, and economic activity at that. It has never held, or even suggested, that *inactivity* is an activity that obstructs or burdens interstate commerce. See Br. of State Respondents 18-28; Br. of Private Respondents 15-19, 32-34, 53.

Legislative action, such as the ACA, that impinges in an entirely novel way on the Constitution's structural division of power and sovereignty raises unique concerns. In *Free Enter. Fund* v. *Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138 (2010), for instance, this Court struck down a novel multilevel for-cause removal restriction on an executive officer. The Court emphasized that the statute at issue was "highly unusual" in light of "the past practice of Congress," and found as "'[p]erhaps the most telling indication of the severe constitutional problem . . . the lack of historical precedent for [such an enactment].'" *Id.* at 3159 (quoting 537 F.3d 667, 699 (D.C. Cir. 2008) (Kavanaugh, J., dissenting)). So it is here.

Even eighty years after the Court first adopted its current broad reading of the Commerce Clause, it is telling indeed that Congress has never before seen fit—even when confronted with a World War, the Cold War, the Great Depression, recessions, oil shocks, farm crises, the savings and loan crisis, and myriad other disruptions great and small—to seek to regulate *abstaining* from economic activity under its Commerce power. And it is particularly troubling in light of this Court's expressed discomfort with extending application of the Clause beyond "economic activity." *Lopez*, 514 U.S. at 559.

The Government's theory in this case reduces to the idea that an individual's failure to purchase health insurance has a negative effect on the interstate market for health insurance, as compared to when individuals uniformly purchase such insurance under Government compulsion. But this bootstrapping rationale is equally true—that is, trivially so—with respect to nearly every individual decision not to participate in commerce: Congress can always conceive of some activity which, if mandated, would substantially affect interstate commerce. Indeed, it is difficult to conceive of an activity that, if mandated of every member of society, would not "substantially affect[]" commerce, whether it would be getting an annual physical or eating an apple a day. Put differently, the Government asks this Court to transform Congress's enumerated power to "regulate" interstate commerce, U.S. Const. art. I, § 8, cl. 3, into the boundless authority to "create" commerce by mandating individual participation, and then to regulate the conscripted participants based on their "involvement" in commerce.

Such a conception of the Commerce Clause is indistinguishable from a plenary federal police power. In the field of health care, Congress could regulate a wide array of personal decisions, such as exercise, diet, or even undergoing particular medical procedures, based on the purported effects of abstention. Nor is the Government's theory limited to health care, as nearly every individual decision can be connected to a market through a potential Government mandate, including decisions about food, clothing, transportation, or education, to name a few.

The Government resists the startling implications of its theory by suggesting the "health care market" is unique because all individuals will participate in it at some point, and participation without insurance shifts costs to others. Br. of United States 2-3, 7-8, 18-19, 28-29. But the factual premise of the Government's argument is mistaken: not all individuals will receive health care during their lifetimes, due perhaps to religious beliefs or individual preferences. See Br. of State Respondents 26. Many more will receive health care services for which they will pay, without insurance. More importantly, cost-shifting is virtually ubiquitous in the modern welfare state, encompassing not only government involvement in food and housing, but societal safety nets such as bankruptcy protection or Medicaid. And as the Respondents explain, and the Government appears to concede, the cost-shifting in this case is largely of Congress's own creation, stemming from the requirement in the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, that hospitals provide emergency medical care regardless of ability to pay. See Br. of State Respondents 49-50; Br. of United States 7-8.

Congress cannot bootstrap a radical expansion of its Commerce power simply by legislating cost-shifting measures.

The Government's expansive conception of the Commerce power is particularly troubling because protecting the public health is an essential component of the States' traditional police power. "[A] State's power to regulate . . . for the purpose of protecting the health of its citizens . . . is at the core of its police power." *Sporhase*, 458 U.S. at 956. In *Head* v. *New Mexico Board of Examiners in Optometry*, 374 U.S. 424, 428 (1963), for instance, this Court characterized a statute "directly addressed to protection of the public health" as "within the most traditional concept" of the State police power. See also *Hill* v. *Colorado*, 530 U.S. 703, 715 (2000) ("It is a traditional exercise of the States' 'police powers to protect the health and safety of their citizens.'") (quoting *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 475 (1996)). Indeed, in part for this reason, this Court recently recognized that displacing state law by a uniform federal statute in the area of public health would "effect a radical shift of authority from the States to the Federal Government"; on that basis the Court declined to read the federal law to so "alter the federal-state balance." *Gonzales* v. *Oregon*, 546 U.S. at 275.

II. THE INDIVIDUAL MANDATE EXCEEDS CONGRESS'S AUTHORITY UNDER THE NECESSARY AND PROPER CLAUSE, AS INFORMED BY CORE PRINCIPLES OF FEDERALISM

Perhaps recognizing the weaknesses in its arguments, the Government glides over the Necessary

and Proper Clause. The briefs for the Respondents demonstrate persuasively why the Government's argument must be rejected, and ALEC does not attempt to reproduce that analysis. Rather, ALEC again highlights the federalism principles that constrain Congress's authority under the Necessary and Proper Clause, and explains why the individual mandate threatens the State-federal balance of authority.

Congress may "make all Laws which shall be necessary and proper for carrying into Execution [its enumerated] Powers." U.S. Const. art. I, § 8, cl. 18. In Chief Justice Marshall's canonical formulation, the Necessary and Proper Clause grants Congress the "incidental" authority to use "means which are appropriate" to "carr[y] into execution" its enumerated powers. *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 421 (1819). But "[w]hen a 'La[w] . . . for carrying into Execution' the Commerce Clause violates the principles of state sovereignty reflected in" the Constitution's text and structure, it is not "'proper'" and thus "'merely [an] ac[t] of usurpation' which 'deserve[s] to be treated as such.'" *Printz*, 521 U.S. at 923-924 (quoting The Federalist No. 33, at 204 (Alexander Hamilton)); accord *Comstock*, 130 S. Ct. at 1957.

In its most recent exposition of the Necessary and Proper Clause, this Court adopted a multi-factor test for determining the scope of Congress's "incidental" authority. See *Comstock*, 130 S. Ct. at 1965. The conclusion in *Comstock* that a civil-commitment statute could be sustained under the Necessary and Proper Clause depended on several contextual factors, including "the long history of federal involvement," *id.*, in "prison-related mental-health statutes,"

id. at 1958; the fact that the federal law served as a "reasonabl[e] exten[sion]" of past federal statutes, *id.* at 1961; the statute's "narrow scope," *id.* at 1965; and—most relevant here—"the statute's accommodation of state interests," *id.*

A. In Exercising Authority Under The Necessary And Proper Clause, Congress Must Give Proper Account To "[S]tate [I]nterests"

This Court's decision in *Comstock* made clear that Congress's exercise of authority under the Necessary and Proper Clause must "properly account[] for state interests." 130 S. Ct. at 1962; see also *id.* at 1967-1968 (Kennedy, J., concurring in the judgment) ("It is of fundamental importance to consider whether essential attributes of state sovereignty are compromised by the assertion of federal power under the Necessary and Proper Clause . . . ."). Legislation resting on the Necessary and Proper Clause must not "invade state sovereignty or otherwise improperly limit the scope of powers that remain with the States." *Id.* at 1962 (internal quotations and citation omitted). In *Comstock*, the federal civil-commitment statute affirmatively "require[d] accommodation of state interests" and essentially allowed States to "opt out": States had substantial discretion about whether to take custody of an individual; could assert such authority "at any time"; and could displace the federal Government's role entirely by taking custody of a detainee. *Id.* at 1962-1963. In upholding that statute, this Court concluded that its interpretation of the Necessary and Proper Clause would not "confer on Congress a general 'police power, which the Founders denied the National Government and reposed in the States,'" *id.* at 1964 (quoting *Morrison*, 529 U.S.

at 618), because the statute was "narrow in scope," applied to only a "small fraction of federal prisoners," and was "limited" in "reach" to individuals already in federal custody. *Id.* at 1964-1965.

And in *Printz* this Court concluded that a law impinging on aspects of sovereignty reserved to the States under the Constitution was not "proper," but rather a federal "usurpation." *Id.* As the Respondents observe, the Court's emphasis on state interests in *Comstock* and *Printz* is consistent with Founding-era practice, which "'suggests that a "proper" law is one that is within the peculiar jurisdiction or responsibility of the relevant governmental actor.'" Br. of Private Respondents 58 (quoting Gary Lawson & Patricia B. Granger, The "Proper" Scope of Federal Power: A Jurisdictional Interpretation of the Sweeping Clause, 43 Duke L.J. 267, 291 (1993)).

B. The ACA's Individual Mandate Fails To Account For State Interests

There can be little question that the ACA's individual mandate fails to account adequately for state interests and therefore is not a "proper" means of carrying into execution Congress's Commerce power. See *Comstock*, 130 S. Ct. at 1962. The individual mandate "forecloses the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise": the adoption of measures to protect public health and welfare. *Lopez*, 514 U.S. at 583 (Kennedy, J., concurring); see also *Hill*, 530 U.S. at 715. As explained below, the ACA disrupts or displaces a wide range of ongoing State and local policymaking initiatives that reflect the interests and values of particu-

lar States. And, unlike the civil commitment statute at issue in *Comstock*, the ACA's individual mandate gives States no discretion to exempt their citizens and provide an alternate State scheme. Nor do the States retain discretion to oust the federal Government from any "appropriate role" the States would ordinarily have discretion to perform. 130 S. Ct. at 1962-1963.

That the ACA impinges on state sovereignty is hardly a theoretical proposition. Some twelve States (Arizona, Georgia, Idaho, Indiana, Kansas, Louisiana, Missouri, New Hampshire, North Dakota, Tennessee, Utah, and Virginia) have enacted laws expressly guaranteeing their citizens the freedom to choose not to purchase health insurance, and Arizona, Ohio, and Oklahoma have enacted constitutional amendments. See, *e.g.*, Idaho Code § 39-9003; Utah Code § 63M-1-2505.5 (2011); Va. Code Ann. § 38.2-3430.1:1 (West 2011); Ariz. Const. art. 27, § 2 (as approved Nov. 2, 2010).[3] And the lack of any limiting principle for the Government's theory confers on Congress a de facto general police power long reserved to the States. Cf. *Comstock*, 130 S. Ct. at 1964.

III. UPHOLDING THE INDIVIDUAL MANDATE WOULD "DISPLACE STATE POLICY CHOICES" AND STIFLE THE STATES' CONSTITUTIONAL ROLE AS LABORATORIES OF DEMOCRACY

In addition to transgressing specific boundaries on the Commerce power and Necessary and Proper

[3] See also Freedom of Choice in Health Care Act, ALEC, *available at* http://www.alec.org/freedom-of-choice-in-health-care-act.

Clause long recognized by this Court, the ACA's individual mandate (and related provisions) "displace state policy choices," *Lopez*, 514 U.S. at 561 n.3 (internal quotations and citation omitted), discouraging innovation and preventing "a single courageous State [from], if its citizens choose, serv[ing] as a laboratory; and try[ing] novel social and economic experiments without risk to the rest of the country." *New State Ice*, 285 U.S. at 311 (Brandeis, J., dissenting). ALEC and its member legislators have considerable experience with an evolving array of State and local initiatives to reform the health insurance market and to make health care more affordable through market-driven, cost-effective mechanisms.

Federal respect for States' traditional roles as policy innovators preserves for them great flexibility in exercising their general police power. In recent years, numerous States have successfully enacted the kinds of market-based, cost-effective solutions for implementing health care reform at the State and local level that ALEC and its member legislators have long advocated. In this brief, ALEC highlights only a few examples of initiatives that will be disrupted and, in some cases, directly displaced by the ACA's homogenizing federal approach—not only through the individual mandate, but also related provisions, such as the establishment of State-level high-risk pools governed by federal eligibility rules. The details of particular State-level initiatives necessarily vary, but even a general survey of some ongoing policy initiatives demonstrates the significant federalism costs of sustaining the ACA's blanket approach.

The federalism costs of the ACA's rush to legislative judgment are particularly high because many of

these State-level initiatives are of recent vintage. The field of health care regulation is not, as some of petitioners' *amici* claim, an instance of State reforms failing after being given a fair trial. See Maryland Br. 20-24. It is, rather, an instance of a homogenizing federal mandate being forced down to interrupt an active and ongoing State-level dialogue just as it has begun to yield results in a critical mass of States, and just as the promise of State-level reform has started to be apparent. By imposing a uniform federal mandate, the ACA not only displaces promising initiatives before they have had adequate opportunity to prove their value, but also forestalls other States from learning from, adapting, and improving upon policies with a demonstrated record of success.

One particularly significant trend of State-level innovation is the creation by some 35 States of high-risk pools that provide insurance for individuals with preexisting health conditions—prior to, and outside of, the similar pools required by the ACA.[4] These

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[4] See Ala. Code §§ 27-52-1 to -6 (West 2010); Alaska Stat. §§ 21.55.010 to .500 (2010); Ark. Code Ann. §§ 23-79-501 to -513 (2011); Cal. Ins. Code §§ 12700-12739.4 (West 2011); Colo. Rev. Stat. § 10-8-501 to -534 (2010); Conn. Gen. Stat. Ann. § 38a-556 (West 2011); Fla. Stat. Ann. §§ 627.648 to .6498 (West 2011); Idaho Code Ann. §§ 41-5501 to -5511 (West 2011); 215 Ill. Comp. Stat. Ann. 105/1 to 105/15 (West 2011); Ind. Code Ann. §§ 27-8-10-1 to -11.2 (West 2011); Iowa Code Ann. §§ 514E.1 to .11 (West 2011); Kan. Stat. Ann. §§ 40-2117 to -2131 (West 2011); Ky. Rev. Stat. Ann. §§ 304.17B-001 to -037 (2011); La. Rev. Stat. Ann. §§ 22:1201 to :1215 (2010); Md. Code Ann., Ins. §§ 14-501 to -508 (2010); Minn. Stat. Ann. § 62E-10 (West 2011); Miss. Code Ann. §§ 83-9-201 to -222 (West. 2010); Mo. Ann. Stat. §§ 376.960 to .989 (West 2011); Mont. Code Ann. §§ 33-22-1501 to -1524 (West 2011); Neb. Rev. Stat. §§ 44-4216 to -4233 (West 2010); N.H. Rev. Stat. Ann. §§ 404-G:5-a to :5-g (West 2011); N.M. Stat. Ann.

State high-risk pools provide coverage for individuals who would otherwise be denied access to individual market health insurance because of pre-existing conditions. ALEC's model High-Risk Health Insurance Pool Act spreads the cost of insuring high-risk individuals across all insurance carriers doing business in a State, without the need for an individual mandate. The federal health exchanges created by the ACA prohibit denying coverage or adjusting premiums based on individual health status, and limit cost-sharing. See 42 U.S.C. §§ 18031-18033. As a result, individuals enrolled in existing State high-risk pools will likely switch to plans created under the ACA.[5]

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§§ 59A-54-1 to -21 (West 2010); N.C. Gen. Stat. §§ 58-50-175 to -255 (West 2010); N.D. Cent. Code Ann. §§ 26.1-08-01 to -14 (West 2009); Okla. Stat. Ann., tit. 36, §§ 6531-6545 (West 2011); Or. Rev. Stat. § 735.600 to .650 (2009); S.C. Code Ann. §§ 38-74-10 to -90 (West 2010); S.D. Codified Laws §§ 58-17-115 to -130 (West 2010); Tenn. Code Ann. §§ 56-7-2901 to -2916 (West 2010); Tex. Ins. Code Ann. §§ 1506.001 to .305 (West 2009); Utah Code Ann. §§ 31A-29-101 to -123 (West 2010); Wash. Rev. Code Ann. §§ 48.41.010 to .910 (West 2011); W. Va. Code Ann. §§ 33-48-1 to -12 (West 2011); Wis. Stat. Ann. §§ 149.10 to .53 (West 2011); Wyo. Stat. Ann. §§ 26-43-101 to -114 (West 2010).

[5] The ACA may also undermine, even without displacing, a promising trend of faith-based, voluntary, health care cost-sharing arrangements facilitated by exemptions from regulation under State insurance codes. Some sixteen States have created regulatory exemptions for such cost-sharing initiatives, through which more than 110,000 Americans share more than $75 million per year for one another's health costs. See Ariz. Rev. Stat. Ann. § 20-122 (West. 2011); Fla. Stat. Ann. § 624.1265 (West 2011); Ga. Code Ann. § 33-1-19 to -20 (West 2011); Iowa Code Ann. § 505.22 (West 2011); Kan. Stat. Ann. § 40-202(j) (West 2010); Ky. Rev. Stat. Ann. § 304.1-120(7) (West 2010); 956 Mass. Code Regs. Ann. § 5.03(4)(c) (West 2011); Me. Rev. Stat. Ann. tit. 24-A, § 704-3 (West 2011); Md. Code Ann., Ins. § 1-202 (West

ALEC has also pursued incentive-based, market-driven solutions through amendments to State public health and tax codes that may be undermined, if not directly displaced, by the ACA. ALEC's model Cancer Drug Donation Program Act, for instance, establishes a voluntary system for cancer patients to donate unused prescription drugs to uninsured and underinsured patients. Nine states have established repositories to secure prescription drug access in this manner.[6] Similarly, ALEC has developed model legislation to provide tax deductions for qualified expenses related to organ donation by living donors; sixteen states have enacted some form of this legislation, helping defray costs of organ donation that are not covered by traditional insurance.[7]

2010); Mo. Ann. Stat. § 376.1750 (West 2011); N.C. Gen. Stat. Ann. § 135-45 to -48 (West. 2011); Okla. Stat. Ann., tit. 36, § 110(11)(a)-(e) (West 2011); 40 Pa. Stat. Ann. § 23(b) (West 2010); Utah Code Ann. § 31A-1-103(3)(c) (West 2010); Va. Code Ann. §§ 38.2-6300 to -6301 (West 2010); Wis. Stat. Ann. § 600.01(1)(b)(9) (West 2011).

[6] See Colo. Rev. Stat. Ann. § 25-35-103 (West 2011); Fla. Stat. Ann. § 499.029 (West 2011); Ky. Rev. Stat. Ann. §§ 194A.450 to .458 (West 2010); Mich. Comp. Laws. Ann. § 333.17780 (West 2011); Minn. Stat. Ann. § 151.55 (West 2011); Mont. Code Ann. § 37-7-1401 (2009); Neb. Rev. Stat. §§ 71-2422 to -2430 (2010); Nev. Rev. Stat. Ann. §§ 457.400 to .490 (West 2010); 62 Pa. Cons. Stat. Ann. §§ 2921-2927 (West 2010).

[7] See Ark. Code Ann. §§ 26-51-2101 to -2103 (West 2010); Ga. Code Ann. § 48-7-27(13)(A)-(B) (West 2010); Idaho Code Ann. § 63-3029K (West 2011); Iowa Admin. Code 701-40.66(422) (2011); La. Rev. Stat. Ann. § 47:297(N)(1)-(2) (2010); Minn. Stat. Ann. § 290.01(19b)(12) (West 2010); Miss. Code Ann. § 27-7-18 (5)(A)-(B) (West 2010); N.D. Cent. Code Ann. § 57-38-30.3(2)(j) (West 2009); N.M. Stat. Ann. § 7-2-36 (West 2010); N.Y. Tax Law § 612(38)(A)-(B) (McKinney 2010); Ohio Rev. Code Ann. § 5747.01(A)(25) (West 2010); Okla. Stat. Ann., tit. 68,

ALEC has also worked to help states eliminate barriers to competition in the insurance market, for instance through the model Health Care Choice Act for States, which allows individuals to purchase quality, affordable health insurance across state lines. To date, 28 states have introduced—and Georgia, Maine, and Wyoming have enacted—such legislation, which expands coverage choices and lowers costs.[8] Health care choice legislation highlights an additional benefit from a pluralistic, State-based approach: the substantial cost savings and efficiencies to be gained by fostering interstate competition in the provision of health insurance. See, *e.g.*, Sven R. Larson, *The Health Care Choice Act: Lowering Costs by Allowing Competition in the Individual Insurance Market*, Prosperitas, vol. 9 (Oct. 2009). Indeed, the nonpartisan Congressional Budget Office concluded that permitting interstate competition in insurance sales would cut health care costs by five percent and save the Government $12 billion.[9]

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§ 2358(E)(21)(A)-(B) (West 2011); R.I. Gen. Laws. Ann. § 44-30-12(7) (West 2010); Utah Code Ann. § 59-10-1015 (West 2010); Va. Code Ann. § 58.1-322(D)(13) (West 2010); Wis. Stat. Ann. § 71.05(1)(i)(1)-(3) (West 2010).

[8] See Ga. Code Ann. § 33-29A-30 (West 2011); Wyo. Stat. Ann. § 26-18-205 (West 2010). Maine recently enacted insurance choice across state lines, but restricted the eligible area to the New England region. See Me. Rev. Stat. Ann. tit. 24-A, § 405-A (West 2011). The Arizona legislature passed a health care choice provision in Senate Bill 1593, which was vetoed by the Governor.

[9] See Congressional Budget Office Cost Estimate, H.R. 2355, Health Care Choice Act of 2005 (Sept. 12, 2005), *available at* http://www.cbo.gov/doc.cfm?index=6639&type=0.

ALEC has also supported legislation to provide a State-level institutional check on mandated health insurance benefits (*i.e.*, benefits individuals are required to "purchase" if they want to buy health coverage at all). Twenty-seven states have enacted mandated benefits review, helping to curb high-cost mandates that keep health coverage unaffordable.[10]

ALEC has considerable experience in State-level policy initiatives that ensure health care access for the poor. In August 2010, ALEC approved its model Patients First Medicaid Reform Act, which establishes Medical Savings Accounts for Medicaid beneficiaries, allowing individuals to use the accounts to purchase a high-deductible health policy and pay for out-of-pocket medical expenses. And, in 2008, ALEC developed a model State Children's Health Insurance

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[10] See Ariz. Rev. Stat. Ann. §§ 20-181 to -183 (2011); Cal. Health & Safety Code §§ 127660-127665 (West 2011); Colo. Rev. Stat. Ann. § 10-16-103 (West 2011); Fla. Stat. Ann. § 624.215 (West 2011); Ga. Code Ann. §§ 33-24-60 to -67 (West 2010); Haw. Rev. Stat. §§ 23-51, -52 (West 2010); Ind. Code Ann. § 27-1-3-30 (West 2011); Kan. Stat. Ann. §§ 40-2248 to -2249 (West 2010); Ky. Rev. Stat. Ann. § 6.948 (West 2010); La. Rev. Stat. Ann. § 24:603.1 (2010); Me. Rev. Stat. tit. 24-A, § 2752 (2010); Md. Code Ann., Ins. §§ 15-1501 to -1502 (West 2010); Mass. Gen. Laws Ann. ch. 3, § 38C (West 2011); Minn. Stat. Ann. § 62J.26 (West 2010); N.H. Rev. Stat. Ann. § 400-A:39 (2010); N.J. Stat. Ann. § 17B:27D-1 to -9 (West 2011); N.Y. Ins. Law § 213 (McKinney 2010); N.D. Cent. Code Ann. § 54-03-28 (West 2009); Ohio Rev. Code Ann. §§ 103.144 to .146 (West 2011); Or. Rev. Stat. Ann. §§ 171.870, .875, .880 (West 2011); Pa. Code, tit. 28, ch. 931 §§ 1-4; Tenn. Code Ann. § 3-2-111 (West 2010); Tex. Ins. Code Ann. §§ 38.251 to .254 (West 2009); Utah Code Ann. § 36-12-5 (West 2010); Va. Code Ann. § 2.2-2505 (West 2010) ; Wash. Rev. Code Ann. §§ 48.47.005, .010, .020, .030 (West 2011); Wis. Stat. Ann. § 601.423 (West 2011).

("SCHIP") Anti-Crowd Out Act, which encourages the use of private insurance by offering premium assistance to individuals who are eligible for SCHIP, but also have access to employer-sponsored coverage. ACA disrupts these and other innovative proposals while they are still in the pipeline of policy development.[11]

This brief has set forth only a handful of examples of the recent and ongoing state legislative initiatives for health care reform; there are numerous others. The existence of this wide range of ongoing policy initiatives belies the suggestion, raised by some states as *amici*, that individual States have "disincentives" to reform health care and health insurance markets, for instance because of a risk that successful policies would become a magnet for migration by the needy and dependant, or because private insurance providers might flee a State adopting restrictive insurance practices. See Maryland Br. 15-18; Br. of the Governor of Washington as *Amicus Curiae* 22-26. Moreover, a growing number of studies provide strong empirical evidence that successful State policies are likely to "diffuse" elsewhere when States have freedom to tailor their local policies. See, *e.g.*, Craig Volden, *States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program*, 50 Am. J.

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[11] To similar effect, ALEC's model Long Term Care Tax Credit Act provides a state income tax credit to encourage seniors to purchase private insurance to meet their needs and preserve Medicaid for the truly needy. ALEC's model Medical School Loan Repayment Act encourages physicians to practice in underserved areas by requiring the state to repay up to $50,000 of medical school loans for a physician who agrees to practice in a "medical shortage" area.

Pol. Sci. 294 (2006). In particular, one study has demonstrated that "changes that reined in the cost of the CHIP program were made in ways that emulated the cost-saving activities of successful governments elsewhere." *Id.* at 310. The importance of the State interests at stake here counsels caution, not haste, before Congress may determine that State efforts are fruitless and force a uniform federal program on unwilling States that are still experimenting with their own solutions.

* * * * *

In a system that fosters pluralism among the several States, it is unsurprising that some States, acting as *amici* to this Court, apparently welcome the policies reflected in the ACA notwithstanding potential infringement on their sovereignty. See Maryland Br. 24-29; see also Br. of the Governor of Washington 33-37; Br. of State Legislators 2. But direct federal involvement in an area of high costs and frequent State budget shortfalls raises federalism concerns of a different sort: the potential to discourage States' traditional innovation and instead foster dependency on the central Government in an area of traditional State responsibility. In part for this reason, "[S]tate acquiescence to federal regulation cannot expand the bounds of the Commerce Clause," under which Congress's authority cannot be "'enlarged'" by the "'non-exercise of state power.'" *Raich*, 545 U.S. at 29 (quoting *United States* v. *Darby*, 312 U.S. 100, 114 (1941)). In other words, "[w]here Congress exceeds its authority relative to the States, . . . the departure from the constitutional plan cannot be ratified by the 'consent' of State officials." *New York*, 505 U.S. at 182.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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