No. 11-398

IN THE

Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Petitioners,

V.

FLORIDA, ET AL.,

Respondents.

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

BRIEF *AMICUS CURIAE* OF THE INDEPENDENT WOMEN'S FORUM IN SUPPORT OF RESPONDENTS (Individual Mandate)

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QUESTION PRESENTED

Whether the minimum coverage provision of the Affordable Care Act exceeds Congress' powers under Article I of the Constitution?

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INTEREST OF THE *AMICUS*[1]

Amicus, The Independent Women's Forum, is a non-partisan, 501(c)(3) research and educational institution that believes women and their families are best served by greater economic and personal freedom and limited government. *Amicus* is gravely concerned that the Affordable Care Act represents a significant, unconstitutional increase in federal power, which if allowed to stand will limit competition, stifle debate and thus deprive us of the liberties and opportunities we would otherwise enjoy.

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[1] The parties have consented to the filing of this brief, and such consents are on file with the Court. As required by Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person other than the *amicus*, its members, and its counsel made any monetary contribution intended to fund the preparation or submission of this brief.

CONSTITUTIONAL AUTHORITY

The Congress shall have Power To . . . regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes . . . . U.S. Const. art. I, § 8, cl. 3.

SUMMARY OF ARGUMENT

The principal reason for giving the commerce power to Congress was to equip it to overcome the various protectionist schemes adopted by the States under the Articles of Confederation. The Commerce Clause was born with a pro-competition bias.

The commerce power is limited in order to secure the people's freedom from undue federal centralization. The Constitution reserves to the States the power over all matters not delegated to the federal government. Thus, the federalist structure of the Constitution functions by "protecting the integrity of the governments themselves," and also by "protecting the people, from whom all governmental powers are derived." *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011).

This Court has consistently insisted that this structure be respected and that the federal government's enumerated powers remain within their due limits. In particular, this Court has refused to allow federal power to expand merely because of the magnitude or the urgency of the particular issue at hand. For example, it has insisted on adherence to the limits to section five of the Fourteenth Amendment, regardless of how worthy the

underlying civil rights project might be. *City of Boerne v. Flores*, 521 U.S. 507 (1997). Similarly, it has refused to allow the federal government to trespass into the people's liberties protected by the Press Clause, notwithstanding dire predictions of immediate and irreparable harm to national security. *New York Times Co. v. United States*, 403 U.S. 713 (1971) (per curiam). So too here. The scope and urgency of the problems allegedly solved by the Affordable Care Act are simply beside the point when the question is whether Congress has exceeded the limits of its power under the Commerce Clause.

A federalism properly conceived respects the free marketplace—a marketplace not just of goods and services, but also of the political ideas necessarily bound up with them. When the Affordable Care Act monopolizes the marketplace concerning health care delivery, it also quashes debate on several profound issues. The most obvious of these issues are the conceptions of justice, charity, liberty, and life itself at stake in health care delivery. To illustrate, the States of Utah and Oregon have adopted very different models to further their citizens' access to health care. These models diverge significantly—both in terms of their structure and in terms of their underlying theory. Utah has adopted a strict, market-based approach, emphasizing access to information and consumer choice. Oregon directly insures qualifying low-income adults and seeks to control costs by rigorously prioritizing and selectively funding particular medical services. The Affordable Care Act largely preempts both—and so closes the laboratory of state innovation—while preempting debate on the larger, crucial questions of how and

why we should choose one system over another to begin with.

Indeed, the Affordable Care Act goes out of its way to nationalize and impose a single federal answer to a number of highly charged questions: Are abortion, sterilization, morning-after pills, and contraception part of the good life that should be available to all, free of charge? Should such availability be subsidized by those who have deep-seated religious convictions to the contrary? To what extent should people be able to dictate their treatment options at the end of their lives? These are big questions that should be open for debate. They should not be summarily silenced by centralized federal authority.

For the federal government to so centralize such a vast area of our nation's economy at the same time it centralizes the answers to such profound moral, philosophical, and religious questions is symptomatic of a pathological breakdown in federalism. It points clearly to a Congress that has breached the limits of its power under the Commerce Clause.

ARGUMENT

The parties and other *amici* will debate the specific boundaries of the commerce power. Our objective is to explain why the commerce power exists at all, why it is limited, and why those limitations are still required to secure the people's freedom.

I. The Commerce Power Exists in Order to Secure the People's Freedom from State Protectionism

The principal motivation for granting Congress its commerce power was the need to dismantle the economic barricades of competing duties, tariffs, and taxes erected by the States under the Articles of Confederation. *H.P. Hood & Sons, Inc. v. Du Mond*, 336 U.S. 525, 533-34 (1949) (opinion by Jackson, J.) (recounting history). Indeed, investigating what was to be done about such barriers to trade was the "sole purpose for which Virginia initiated the movement which ultimately produced the Constitution." *Id.* And New Jersey, which had largely foreseen the problems created by the absence of a federal commerce power, objected to the adoption of the Articles of Confederation in part because they denied to Congress the power to regulate foreign commerce. Joseph Story, *Commentaries on the Constitution of the United States*, § 259 n.1.

In the "more perfect Union" envisioned by the Framers, Congress would be empowered—via the Commerce Clause—to put an end to the States' economic abuses. Ezra Parmalee Prentice & John Garret Egan, *The Commerce Clause of the Federal Constitution* 1-3 (1898); *see also* The Federalist No. 11 (Alexander Hamilton); Nos. 42, 45 (James Madison).

In short, the Commerce Clause was born with a pro-competition bias. That is not to say, of course, that all valid exercises of the commerce power must favor unfettered competition in wide open markets.

See, *e.g.*, *Gonzales v. Raich*, 545 U.S. 1 (2005) (upholding as a valid exercise of the commerce power a statute that closed down the interstate market in marijuana). It is to say that rabidly anti-competitive legislation allegedly authorized by the Commerce Clause should be viewed with suspicion. It may not, by itself, be sufficient to make a diagnosis, but it is certainly a worrisome symptom.

Giving Congress the power to regulate interstate and foreign commerce was not at all controversial, either during the Constitutional Convention or in the ratification debates. Madison said that while the commerce power was admittedly "an addition" to the federal powers, it was one "which few oppose, and from which no apprehensions are entertained." The Federalist No. 45 (James Madison). In other words, everyone was fed up with the States' protectionism. And, anyway, who could imagine any mischief resulting from the power to regulate interstate commerce, of all things?

Notwithstanding the general optimism, Madison was adamant: The Constitution—Commerce Clause and all—reserved to the States power over "all the objects which, in the ordinary course of affairs, concern the lives, liberties, and properties of the people, and the internal order, improvement, and prosperity of the State." The Federalist No. 45 (James Madison).

II. The Commerce Power is Limited in Order to Secure the People's Freedom from Federal Centralization of the Marketplace

As this Court has recently emphasized, the federalist structure of the Constitution operates not only by "protecting the integrity of the governments themselves," but also by "protecting the people, from whom all governmental powers are derived." *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011). "State sovereignty," the Court explained, "is not just an end in itself: Rather, federalism secures to citizens the liberties that derive from the diffusion of sovereign power." *Id.* (quoting *New York v. United States*, 505 U.S. 144, 181 (1992)) (internal quotation marks omitted).

Similarly, the Constitution and its ratifiers "insisted upon a federal structure for the very purpose of rejecting the idea that the will of the people in all instances is expressed by the central power, the one most remote from their control." *Alden v. Maine*, 527 U.S. 706, 759 (1999).

Thus, this Court has repeatedly insisted that the federal powers remain contained within their assigned boundaries, even in the face of great and urgent national problems. The Fourteenth Amendment, proposed and ratified in the wake of the Civil War, greatly altered the balance of power between the federal and state governments. And, if over-generously construed, it could have all but obliterated it. Section five of the Fourteenth Amendment granted Congress the authority to enact

laws to "*enforce* . . . the provisions of this article." U.S. Const. amend. XIV, § 5 (emphasis added). The great temptation courts have faced in construing section five is similar to that occasioned by Commerce Clause cases—to turn the provision into a blank check of federal power in order to engage some exigency or other. This is all the more true in Fourteenth Amendment cases since the circumstances surrounding its adoption were nothing less than Reconstruction, and issues concerning the interpretation to be given to section five inevitably arise in civil rights cases. This Court has nonetheless insisted that section five's grant of power to Congress is limited—limited to the "enforcement" of the Amendment's provisions. And "enforcement" (like "regulation") is no blank check. Enforcement must be "remedial" and must be both "congruen[t] and proportional[]" to the injury being remedied. *City of Boerne v. Flores*, 521 U.S. 507, 519-22 (1997).

Where there is no cognizable injury to be remedied, Congress lacks the power to act under the Fourteenth Amendment, even where acting would seem to serve the broadly defined purposes of the Amendment. *Id.* So too with the Commerce Clause. Its limits do not vary according to the greatness of the cause for which it is invoked.

Nor do the limits of federal power depend on how urgently the federal government presses its case. In 1971, as the New York Times and Washington Post were set to publish excerpts of the "Pentagon Papers," documents concerning the Vietnam War produced by the Department of Defense and classified as "Top Secret—Sensitive," the federal

government sought a prior restraint against their publication. In the secret portion of its briefing to this Court, the federal government declared that publication of certain portions of the Pentagon Papers would cause "immediate and irreparable harm to the security of the United States." Brief of the United States, Secret Portion, at 3, *New York Times Co. v. United States*, 403 U.S. 713, Nos. 1873, 1885 (June 1971), *available at* http://www.gwu.edu/~nsarchiv/NSAEBB/NSAEBB48/griswoldbrief.pdf (last visited Feb. 12, 2012).

Per the government's brief, publication of the sensitive portions of the Pentagon Papers could have (1) compromised on-going negotiations with citizens and government officials in certain foreign nations (some of whom had been negotiating without consent of their governments); (2) offended certain governments through the publication of derogatory statements about particular people; (3) jeopardized or retarded the United States' ability to continue to withdraw troops from Vietnam; (4) compromised the anonymity and security of CIA operatives then active in Southeast Asia; (5) compromised military plans by the Southeast Asia Treaty Organization ("SEATO") to address "communist armed aggression" in Southeast Asia and, potentially, future military cooperation between the United States and SEATO's member nations; (6) revealed to Soviet intelligence information about the capabilities of the United States' intelligence; (7) otherwise harmed the United States' diplomatic relations with the Soviet Union and other nations; (8) breached the trust of military officials in South Vietnam and Laos; and (9)

frustrated negotiations to free prisoners of war. *Id.* at 4-10.

The federal government's national security arguments there were certainly at least as pressing as the economic arguments it makes here. Nevertheless, the Court held in *New York Times* that, notwithstanding the weight of those arguments, the federal government had not met the "heavy burden of showing justification for the imposition of [a prior] restraint." *New York Times Co. v. United States*, 403 U.S. 713, 714 (1971) (per curiam) (internal citation omitted).

Justice Black explained his vote elegantly: "[F]or the first time in the 182 years since the founding of the Republic, the federal courts are asked to hold that the First Amendment does not mean what it says . . . ." *Id.* at 715 (Black, J., concurring). Justice Brennan put it only slightly more prosaically. The First Amendment, he wrote, "tolerates absolutely no prior judicial restraints of the press predicated upon surmise or conjecture that untoward consequences may result." *Id.* at 725-26 (Brennan, J., concurring) (citing *Near v. Minnesota*, 283 U.S. 697, 713 (1931), for the proposition that the "chief purpose of [the First Amendment's] guaranty [is] to prevent previous restraints upon publication" (alternations in original)).

In short, it doesn't matter how great the cause or how urgent the issue. The Commerce Clause gives Congress only limited power to regulate interstate commerce, not plenary power to solve national problems by whatever means are closest to hand. It,

too, "mean[s] what it says." *Id.* at 715 (Black, J., concurring); *see also New York v. United States*, 505 U.S. 144, 187 (1992) ("[T]he Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.") [2]

The limits on the federal commerce power protect freedom in less obvious ways as well. "Federalism secures the freedom of the individual. It allows States to respond . . . to the initiative of those who seek a voice in shaping the destiny of their own times without having to rely solely upon the political processes that control a remote central power." *Bond* 131 S. Ct. at 2364. The federalism that is maintained by restricting Congress to its limited role under the Commerce Clause is thus one that preserves individuals' economic freedom as well as the freedom of the marketplace itself. That freedom includes respecting individuals' ability to "shap[e] the destiny of their own times" by urging state governments to experiment with potential solutions to the problems of the day. *Id.*; *see also Printz v. United States*, 521 U.S. 898, 919-20 (1997) ("[T]he Framers rejected the concept of a central government that would act upon

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[2] Suppose that Congress determined that the rapidly rising costs of dental hygiene were a major drain on our economy and that electronic toothbrushes are more efficient than manual toothbrushes. (Such things are not impossible. *Cf.* Armando Silvestrini-Biavati, et. al., *Manual Orthodontic vs. Oscillating-Rotating Electric Toothbrush in Orthodontic Patients: A Randomised Clinical Trial*, 11 Eur. J. Pediatric Dentistry 200 (2010).) Could Congress, under any of its enumerated powers, lawfully compel each citizen to buy a specific toothbrush?

and through the States, and instead designed a system in which the state and federal governments would exercise concurrent authority over the people."). The States are, after all, "laboratories for experimentation to devise various solutions where the best solution is far from clear." *United States v. Lopez*, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring).

In other words, a properly understood federalism maintains a free marketplace not just of goods and services, but also a free marketplace of the political ideas inextricably tied to them. By contrast, legislation that closes markets in both goods and services and in their underlying ideas is symptomatic of a breakdown of true federalism.

III. Congress' Assertion of Total Power Over Health Care Delivery Improperly Centralizes the Marketplace of Goods, Services—and Ideas

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 ("Affordable Care Act"), monopolizes the marketplace concerning health care delivery. In a purely fiscal sense, the new federal monopoly is obvious. It prevents the States from fielding alternative models of health care delivery that differ significantly from those of the other States and from the federal government. Such diversity of thought was highly prized by the Framers and remains essential. But the Affordable Care Act "forecloses the States from experimenting and exercising their own

judgment in an area to which States lay claim by right of history and expertise." *See Lopez*, 514 U.S. at 583 (Kennedy, J., concurring); *see also Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (observing that the regulation of public health is a police power traditionally within the power of the States and was not surrendered by them upon "becoming a member of the Union under the Constitution."); *cf. Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719 (1985) ("[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern.").

It bears emphasis, however, that it is not just fiscal issues that are at stake in the present assertion of congressional power. Health care is not merely the "widget" of classroom fame, a hypothetical, all-purpose, and all-fungible unit of commerce. Rather, health care issues are inescapably fraught with issues of philosophy, morality, and religious exercise. The decision of how to deliver health care calls into question the underpinnings of what constitutes justice, charity, liberty, and the good life, to name but a few.

A. The Affordable Care Act Improperly Centralizes the Marketplace Concerning Health Care Delivery Systems

The Affordable Care Act asserts that in the United States, health care will hereafter be provided as Congress and the Secretary of Health and Human Services instruct. The congressional method might not be the best one. It is certainly not the only one.

But Congress' power grab forecloses testing of alternative methods. We offer two examples from opposite ends of the spectrum:

The State of Utah opted to reform its health care delivery system by granting greater autonomy to consumers and granting them access to information. The Utah Health Exchange is designed to be a market-based system, driven by consumers rather than government. Utah Governor's Office of Economic Development, *An Overview of the Utah Health Exchange*, http://www.goed.utah.gov/site-media/page-media/files/An_Overview_of_the_Utah_Health_Exchange_final.pdf (last visited Feb. 12, 2012).

Indeed, Utah's health exchange is barely more than a web portal, Utah Health Exchange, *Overview*, http://exchange.utah.gov/about-the-exchange/overview (last visited Feb. 12, 2012), through which (1) participating businesses make a defined contribution to subsidize the health insurance of their employees and (2) employees select among competing health insurance plans and benefits. If the employee wants a plan with a price tag higher than the employer's contribution, the employee has the option of paying the difference. The Commonwealth Fund, *Utah Health Exchange*, States in Action, Feb.-Mar. 2011, http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Snapshots/Utah.aspx.

Utah's exchanges are significantly different from the complex network created by the Affordable Care Act.

> Compared with the requirements of the Affordable Care Act . . . in standardizing benefit design and setting and monitoring cost and quality standards, the Utah Health Exchange's approach has been more passive, letting the private market compete under limited oversight and guidelines. Working with a very modest budget ($650,000 annual allotment from the state), administrators view their exchange as first and foremost a technical platform, whereby the state contracts with private companies that own and run the software.

Id.[3]

Have Utah's measures met their goals of both increasing access and decreasing costs? We may never know. The program piloted in 2010 and will soon be preempted by the Affordable Care Act.

At the other end of the spectrum, Oregon has adopted a quite different model. It seeks to control costs by directly insuring qualifying low-income adults. In order to control costs, the State created an agency that prioritizes various medical services, literally ranking them in order of their priority as determined by that agency. Oregon Health

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[3] For more on Utah's reform program, see Edmund Haislmaier, *State Health Reform: The Significance of Utah Health Insurance Reforms*, The Heritage Foundation, July 29, 2009, http://www.heritage.org/research/reports/2009/07/state-health-reform-the-significance-of-utah-health-insurance-reforms.

Authority, The Prioritized List, http://www.oregon.gov/OHA/healthplan/priorlist/main.shtml (last visited Feb. 12, 2012). The state legislature appropriates a certain amount of money to operate the Oregon Health Plan and, presumably based on historical data, the plan determines which items on the prioritized list it can afford to cover. It draws a line—currently after priority number 498 of 692—and all medical services that appear below that line receive no coverage under the plan. Oregon Health Authority, Current Prioritized List of Health Services, http://www.oregon.gov/OHA/OHPR/HERC/Current-Prioritized-List.shtml (last visited Feb. 12, 2012).

The federal plan will largely supplant Oregon's. While we would not have chosen it, Oregon's legislators did. They should be free to experiment. And, provided that Oregon rigorously studies its program and releases reliable data on it, we all benefit from their efforts. The Affordable Care Act will end that experimentation.

B. The Affordable Care Act Improperly Centralizes the Marketplace Concerning Important Moral and Social Issues

What is more, the Affordable Care Act actually goes out of its way to nationalize and impose a single answer to the highly-charged questions of whether abortion, sterilization, morning-after pills, and contraception generally should be subsidized by virtually all Americans, regardless of their consciences and religious beliefs. It will no doubt do

the same for end-of-life issues. This is nothing short of a legal and societal earthquake.[4]

1. Abortion

Section 1303 of the Affordable Care Act, as amended, 42 U.S.C. § 18023, coerces private subsidization of abortion. It does so by compelling private individuals to pay into a fund that will be used solely for abortion coverage, while not even adequately informing them of that development. It provides no exemption for those conscientiously opposed to abortion.

The Affordable Care Act permits the issuer of a "qualified health plan"—a term defined by 42 U.S.C. § 18021 to include essentially *every* health plan not otherwise exempted by the Affordable Care Act—to provide abortion coverage. § 18023(b)(1)(A)(ii). And while the issuer's decision to include abortion within its coverage is subject to veto by the State in which the plan is offered, § 18023(a), individual conscientious objectors—those who are actually required to *pay* for the abortion coverage—are offered no such option. For them, whether their plan includes abortion coverage or not is merely a confluence of events that, for most people, are only partially under their control.

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[4] *Amicus* takes no position on the ultimate answers to these moral and social questions. We simply urge that individuals continue to have the opportunity to discuss and debate them and draw their own conclusions. And we take strong exception to the federal government's efforts to preempt the discussions, shut down the debates, and impose on the people its own preferred answers to these questions.

The Affordable Care Act provides that funding for abortion coverage will be segregated from the general funds of plans providing that coverage. § 18023(b)(2)(B)-(C). Funds for "abortions for which public funding is prohibited" (that is, all abortions other than those sought following an act of rape or incest or when the life of the mother is endangered, *see* Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (Mar. 24, 2010)) (hereafter "non-exempted abortions"), must be collected separately and retained in separate accounts. § 18023(b)(2)(C). Because federal funds may not be used to cover non-exempted abortions, § 18023(b)(2)(A), the funding for non-exempted abortions must come from plan participants.

In order to ensure adequate funding for abortion coverage, the Affordable Care Act *mandates* that issuers of plans providing coverage for non-exempted abortion collect money for that coverage from each enrollee. § 18023(b)(2)(B). That money will go into a segregated account to be used for the sole purpose of paying for non-exempted abortions. § 18023(b)(2)(C)(ii)(II).

Importantly, *all* members of the plan are required to pay into the segregated account that will be used, perhaps against their will and perhaps even without their prior knowledge, to fund non-exempted abortions. The Affordable Care Act requires plan issuers to "collect from each enrollee in the plan *(without regard to the enrollee's age, sex, or family status)* a separate payment for . . . an amount equal to the actuarial value of the coverage of [non-exempted abortions]." § 18023(b)(2)(B) (emphasis

added). That actuarial value is defined statutorily to be not less than "$1 per enrollee, per month," § 18023(b)(2)(D)(ii), thus guaranteeing that each enrollee in such a plan will pay something from their own funds every month to subsidize the non-exempted abortions of enrollees.

The abortion provisions, read together with the individual mandate, 26 U.S.C. § 5000A, compel the subsidization of abortion by nearly every U.S. citizen, national, and legal alien.

Objecting individuals do not necessarily have the option of enrolling in qualified care that does not provide abortion. First, individuals who will receive insurance coverage through their employers might not be permitted to choose their health plan. (Under the current regime, health insurance contracts between employers and employees are quite often unilateral "take-it-or-leave-it" contracts. Meir Katz, *Towards a New Moral Paradigm in Healthcare Delivery: Accounting for Individuals*, 36 Am. J.L. & Med. 78, 82 & n.13-15 (2010)).

Second, the Affordable Care Act does not ensure the existence of an option to join a plan that does not subsidize abortion. A prior version of the Act, one passed by the House of Representatives, would have mandated that each health insurance market contain at least one plan that does not offer abortion coverage. H.R. 3590, 111th Cong. § 1303(a)(1)(D) (2010). But, as adopted, the Act contains only a watered-down version of that provision, ensuring choice only with respect to multi-state plans. 42 U.S.C. § 18054(a)(6). Thus, in States that opt not to

ban abortion coverage, *see* § 18023(a), or where no multi-state plan option exists, nearly all citizens, nationals, and legal aliens will be required to individually and directly subsidize abortion.

Not only does the Affordable Care Act compel private subsidy of abortion, it does so without providing adequate notice to the compelled supporters. The Act requires plans that cover non-exempted abortions to notice enrollees "*only* as part of the summary of benefits and coverage explanation, at the time of enrollment." § 18023(b)(3) (emphasis added). By implication, further disclosure is prohibited.

Moreover, the Act goes out of its way to camouflage the abortion subsidies that it compels. The Act mandates that advertising used by the plan's issuer and information provided by the insurance exchange(s) in which it participates "shall provide information only with respect to the total amount of the combined payments for services." *Id.* In other words, the abortion subsidy will not receive a separate line item or be otherwise identified. As a result, the public will be uninformed and participants will have a limited ability to figure out that they are personally and directly subsidizing abortion.[5]

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[5] This might not have been unintentional. The individual mandate exempts people who conscientiously object to accepting the benefits of public or private insurance generally. 26 U.S.C. § 5000A(d); 26 U.S.C. § 1402(g). It does not exempt people who conscientiously object to abortion. The drafters of the Act clearly knew how to create an exemption and opted instead to compel private subsidy of abortion as broadly as possible.

There is a good reason that non-exempt abortion is described by the Affordable Care Act as "abortion for which public funding is prohibited." Congress has prohibited the federal government from financing abortions at least since the Hyde Amendment was first enacted in 1976. *See* National Committee for A Human Life Amendment, *The Hyde Amendment*, http://www.nchla.org/datasource/ifactsheets/4FSHydeAm22a.08.pdf (Apr. 2008). This Court upheld the constitutionality of that congressional practice in 1980. *Harris v. McRae*, 448 U.S. 297 (1980). Congress presumably decided to so restrict funding for abortion because of the "profound moral and spiritual implications" tied up in abortion decisions. *Planned Parenthood v. Casey*, 505 U.S. 833, 850 (1992).

"Millions of Americans believe that life begins at conception and consequently that an abortion is akin to causing the death of an innocent child." *Stenberg v. Carhart*, 530 U.S. 914, 920 (2000). Their moral objections should not be summarily silenced by centralized national health care.

2. Sterilization, Contraception, and Abortion-Inducing Drugs

A seemingly innocuous provision of the Affordable Care Act, 42 U.S.C. § 300gg-13(a)(4), provides that group health plans and health insurance issuers offering group or individual coverage must provide women free coverage for "preventive care and screenings . . . as provided for in comprehensive guidelines" to be issued subsequently through administrative regulation. In interpreting

"preventive care" for the purpose of issuing its regulations, HHS sought the recommendations of the Institute of Medicine (IOM), an outside research organization. When the IOM recommended that HHS mandate that all covered insurance providers offer, free to the insured, "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity," Institute of Medicine, *Clinical Preventive Services for Women* 102-110 (2011), *available at* http://books.nap.edu/openbook.php?record_id=13181, HHS formally adopted those recommendations in less than two weeks. Institute of Medicine, *Women's Preventive Services Recommended by IOM to be Covered Under Affordable Care Act*, http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/Action-Taken.aspx (last visited Feb. 12, 2012).

HHS's final regulations thus interpret "preventive care and screenings," to extend well past screening for breast and cervical cancer, to include "contraceptive methods[and] sterilization procedures." *See* 45 C.F.R. § 147.130(a)(1)(iv) (referring to "binding comprehensive health plan coverage guidelines" to be published independently); Health Resources and Services Administration, *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines (last visited Feb. 12, 2012).

The regulations permit the *discretionary* grant of exemptions to only those providers that meet each of

four criteria which, taken together, appear to apply only to churches and monasteries. 45 C.F.R. § 147.130(a)(1)(iv). Religious organizations that have a *bona fide* conscientious objection to the free provision of contraception but, for example, employ members of other faiths or serve the general public cannot receive an exemption. *See* 45 C.F.R. § 147.130(a)(1)(iv)(B)(2)-(3). Their options are to forego their beliefs, pay massive fines, or cease to exist.

After many religious organizations protested that the regulations compelled the violation of their religious convictions, HHS revised the regulations. But only a little—by one year to be exact. The administration "feint[ed] at a compromise" with such organizations by awarding them "another year to figure out how to . . . spend their own money in a way that contradicts the tenets of their faith." Editorial, *Respecting Religious Exemptions*, Wash. Post, Jan. 23, 2012, at A16.

This change did little to satisfy the religious community, so the President has just announced yet another one. The President decreed the regulations would be changed. Those regulations would now require insurance carriers for religious "charities" and schools to affirmatively offer, free of charge, the coverage in question to the religious organizations' employees. White House Office of the Press Secretary, *Fact Sheet: Women's Preventive Services and Religious Institutions*, Feb. 10, 2012, http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions.

But even assuming this is a valid use of the Executive's authority, the underlying economic reality will not have changed. The same insurance companies will be providing the same benefits to the same individuals. What is more, unless those insurance companies—and their shareholders—are prepared to forego some of their profit, they will necessarily be charging the same religious employers the same premiums as before. The only difference is there will not be any awkward line items for contraceptive services etc. on the invoices.

Moreover, even taken on its own terms, the President's new policy does nothing for the large number of religious organizations that self-insure their employees and are thus both the employer and the insurer. It likewise does nothing for for-profit organizations, such as religious bookstores, or for the large numbers of conscientious objectors in the general economy. *See* United States Conference of Catholic Bishops, *Bishops Renew Call to Legislative Action on Religious Liberty*, Feb. 10, 2012, http://www.usccb.org/news/2012/12-026.cfm.

In short, the problems with the President's ever-changing program are not subsiding, they are multiplying. They are further symptoms of the constitutional infirmity of the Affordable Care Act itself.

At least three federal lawsuits challenging the contraceptive mandate are currently pending under the Religious Freedom Restoration Act and the Free Exercise Clause. *Eternal World Television Network v. Sebelius*, No. 12-cv-00501 (N.D. Ala. filed Feb. 9,

2012); *Colorado Christian University v. Sebelius*, No. 11-cv-3350 (D. Colo. filed Dec. 22, 2011); *Belmont Abbey College v. Sebelius*, No. 11-cv-1989 (D.D.C. filed Nov. 10, 2011).

Whether contraception ought to be available free of charge to all who want it is an important and complex social question that ought to be left open to debate. We fear that the failures by Congress and the Executive Branch to exempt conscientious objectors is but a "precursor of the state's hostility" to ideas that it disagrees with. *See United States v. Penn*, 647 F.2d 876, 889 (9th Cir. 1980) (en banc) (Kennedy, J., dissenting).

3. End-of-Life Decisions

Similarly, the Affordable Care Act will inevitably give to the federal government influence over countless decisions relating to end-of-life care. While neither the Act itself nor HHS's current regulations yet compel end-of-life "counseling," (despite a considerable effort by Congress and the Executive Branch to include the same), Ricardo Alonso-Zaldivar, *End-of-Life Planning Dropped from Medicare Checkup Rules*, Wash. Post, Jan. 6, 2011, the federal government's increased involvement in medicine and determination to cut costs is destined to lead to a greater involvement in medical choices, including those relating to end-of-life care.

Obviously, the federal government already has control over Medicare coverage limitations, *see* Centers for Medicare and Medicaid Services, *Medicare: Overview*, Jan. 20, 2012,

http://www.cms.gov/CoverageGenInfo, and thus has great latitude to deny coverage for treatment that it deems wasteful. And the Affordable Care Act plainly indicates an intent to exercise that latitude by creating the "Independent Medicare Advisory Board," the purpose of which is to "reduce the per capita rate of growth in Medicare spending." 42 U.S.C. § 1395kkk(b). While the Advisory Board may not recommend any "restrict[ion of] benefits or modif[ication of] eligibility criteria, § 1395kkk(c)(2)(ii), it may recommend the reduction of reimbursement rates to physicians and, starting in 2019, hospitals. *See* § 1395kkk(c)(2); 42 USC § 1395x(u). Reducing physician reimbursement rates on particular procedures will have precisely the same effect as overt rationing as many physicians will be unwilling to offer services for which they will inadequately compensated.[6]

But the federal government's influence over the health industry extends far beyond actually denying coverage or instituting other rationing measures. The Affordable Care Act places the regulation of health care (for the entire population, not just the elderly and poor) within the ambit of the federal government. The government will no doubt seek to create disincentives to the provision of private care that it deems wasteful.

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[6] Per the terms of the Affordable Care Act, the Advisory Board's "recommendations" are subject to limited debate by the Senate, 42 U.S.C. § 1395kkk(d)(4), and automatically become law unless Congress takes affirmative action to the contrary. 42 U.S.C. § 1395kkk(e).

End-of-life care occupies a considerable percentage of total health care expenditures—by some estimates, 22%. Donald R. Hoover, et al., *Medical Expenditures During the Last Year of Life: Findings from the 1992–1996 Medicare Current Beneficiary Survey*, 37 Health Services Res. 1625, 1635 (2002). And 26% of the annual Medicare budget is used on the same population. *Id.* at 1635-36. Roughly 30% of those terminal-year expenses are made in the final month of life. *Id.* at 1636. Reducing the expenses of end-of-life care thus becomes an attractive goal for those dedicated to reduce total medical expenses.

The federal government's influence has tremendous moral and social implications. It might decide, as the United Kingdom did, to deny (or create disincentives for) coverage for dialysis to patients over sixty-five years old or to patients with other health complications who are just fifty-five years old. *See* Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. Pa. L. Rev. 1597, 1612 (1992). Or it might decide to limit access to medical resources for comatose patients who desire (more accurately, whose surrogates desire for them) to be kept alive. This Court has strongly suggested that even incapacitated patients have a right to be kept alive if they wish to be. *See Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279-82 (1990); *Washington v. Glucksberg*, 521 U.S. 702, 728-34 (1997). How will those patients enforce that right if the federal government has stacked the deck against them?

These concerns are not fanciful. Dr. Ezekiel Emanuel, a health advisor to the President and the brother of his former chief of staff, wrote in 2008 that he desires a health reform that alters doctors' ethical obligations. Dr. Emanuel wants to compel doctors to provide what he calls "socially sustainable, cost-effective care." Ezekiel Emanuel, *The Cost-Coverage Trade Off*, 299 JAMA 947 (2008). For Dr. Emanuel, that means teaching physicians to think less of the needs of *their* patients and more of the societal need to ration care. Betsy McCaughey, *Obama's Health Rational-in-Chief*, N.Y. Times, Aug. 27, 2009.

Dr. Emanuel added that drastic measures, such as the ones he proposes, are necessary and that "[v]ague promises of savings from cutting waste, enhancing prevention and wellness, installing electronic medical records and improving quality of care are merely 'lipstick' cost control, *more for show and public relations* than for true change." Emanuel, *supra* (emphasis added).

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Important decisions concerning morally and socially significant matters—such as end-of-life care and the subsidization of procedures and devices that large segments of society reject on moral grounds—ought to be the subject of ongoing debate in the public square. That debate should not be summarily silenced by the policy preferences of remote central authorities. At a minimum, there ought to be room for dissent and conscientious objection.

As this Court closed its decision in *Washington v. Glucksberg*, 521 U.S at 735, it noted that: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."

The commerce power, like all enumerated powers, is limited. It bears repeating: "Federalism secures the freedom of the individual. It allows States to respond . . . to the initiative of those who seek a voice in shaping the destiny of their own times without having to rely solely upon the political processes that control a remote central power." *Bond* 131 S. Ct. at 2364. No doubt, the problem of health care in America is a serious one that would benefit from expeditious action. Nevertheless, "the Constitution commands restraint before discarding liberty in the name of expediency." *J. McIntyre Machinery v. Nicastro*, 131 S. Ct. 2780, 2791 (2011) (plurality opinion).

This is all the more true when confronting a gambit as massive as the Affordable Care Act. For the federal government to so centralize such a vast area of our nation's economy is troubling enough. For it to simultaneously stifle debate on profound moral, philosophical, and religious questions is even more worrisome. Taken together, these two trespasses point clearly to a Congress that has breached the limits of its power under the Commerce Clause.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Eleventh Circuit should be affirmed.

Respectfully submitted,

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