U.S.D.C. No. 10CV91RVEMT

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF FLORIDA

PENSACOLA DIVISION

STATE OF FLORIDA, by and through Bill McCollum, et al,

Plaintiffs,

v.

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

Defendants.

BRIEF OF THE STATES OF OREGON, IOWA, VERMONT, MARYLAND AND KENTUCKY AS AMICI CURIAE

Tom Miller
Iowa Attorney General
1305 E. Walnut Street
Des Moines, IA 50319

William H. Sorrell
Vermont Attorney General
109 State Street
Montpelier, VT 05609-1001

Douglas F. Gansler
Attorney General of Maryland
200 Saint Paul Place
Baltimore, Maryland 21202

Jack Conway
Kentucky Attorney General
700 Capital Ave. Suite 118
Frankfort, KY 40601

John Kroger
Oregon Attorney General
1162 Court Street N.E.
Salem, Oregon 97301-4096

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I. INTERESTS OF THE AMICI STATES

The Amici States have engaged in varied, creative, and determined efforts to expand and improve access to health care and contain health care costs. Despite some successes, these state-by-state efforts have fallen short as states struggle with funding shortfalls and the difficulties inherent in patchwork solutions for a national problem.

The Patient Protection and Affordable Care Act (ACA)[1] is a national solution that will help the Amici States fulfill their goals of protecting and promoting the health and welfare of their citizens. The law provides minimum standards for health insurance policies and coverage and will allow the states to expand and improve health care access. For example, it has been projected that in Oregon the ACA will allow the State to reduce the number of uninsured to just 5% by 2019—a vast improvement over the 27.4% forecast of uninsured by that time without the reforms.[2]

While recognizing the urgent need for national reforms to address the health care crisis, the Amici States also have a keen interest in reforms that will maintain the balance of power between the states and the national government. As states that remain committed to finding innovative ways to improve our citizens' health and welfare, we have a special interest in reforms that respect the principles of cooperative federalism and that allow us to maintain a central role in shaping health care policy within our borders.

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[1] Pub. L. No. 111-148,124 Stat. 119(2010).

[2] Bowen Garrett et al., *The Cost of Failure to Enact Health Reform: Implications for States*, (Robert Wood Johnson Found. & Urban Inst., 2009) *available at*: http://www.urban.org/uploadedpdf/411965_failure_to_enact.pdf (viewed 11/15/2010).

II. INTRODUCTION

A. The current crisis and the need for national reform.

As this Court has recognized, our nation's health care system is in a state of crisis. Order 3, Oct. 14, 2010, ECF No. 79. As of 2008, 43.8 million people in the United States had no health insurance coverage and thus no or little access to health care.[3] Indeed, Congress found that "Half of all personal bankruptcies are caused in part by medical expenses." ACA § 1501(a)(2)(G).[4]

Absent national reform, state-level health care costs will rise dramatically over the next 10 years. These costs include double and triple digit percentage increases in spending by states for uncompensated care, Medicaid, the State Children's Health Insurance Program, as well as massive increases in private insurance premiums and business and individual out-of-pocket health care spending.[5] For example, the Urban Institute has estimated that, by 2019, *absent the ACA*:

- Oregon's spending on Medicaid and SCHIP will increase by between 65.8% and 110.7%.[6]
- The cost of uncompensated care in Oregon will increase by between 80.3% and 137.1%.[7]
- Health insurance premiums for employers in Oregon will increase by between 76.8% and 107.5%.[8]

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[3] The Centers for Disease Control and Prevention, *Early Release of Selected Estimates Based on Data From the 2008 National Health Interview Survey* Table 1.1a (2009), *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/200906_01.pdf (viewed 11/15/2010).

[4] All references to ACA § 1501(A)(2) are to §1501 as amended by § 10106 of the ACA.

[5] Garrett, *supra* note 1, at 51.

[6] *Id*.

[7] *Id*.

These increases threaten to overwhelm already overburdened state budgets. In summary, without a national solution to the health care crisis, for the foreseeable future the Amici States would be forced to spend more and more on health care and yet still slide farther and farther away from their goal of protecting the health and well being of their citizens.[9]

B. The Patient Protection and Affordable Care Act.

The ACA will allow states to expand and improve health insurance coverage. The ACA achieves coverage increases through a variety of mechanisms, including a federally funded expansion of the Medicaid program and the implementation of a minimum coverage provision that requires certain individuals to obtain health insurance or pay a penalty. The requirement is targeted at those who, while they can afford it, make a voluntary and intentional decision to not purchase insurance and instead choose to "self insure," relying on luck, the charity of others and the health care social safety net of emergency rooms and public insurance programs to catch them when they fall ill. In reality, the expense of providing care to self-insured individuals is passed on to everyone in the country and across state boundaries.

The law will expand Medicaid eligibility to all non-elderly adults who earn up to 133% of the poverty line. ACA § 1. Although more people are expected to enroll in Medicaid under the ACA, the federal government will cover 90-100% of the total cost of that nation-wide expansion over the next 10 years, while state Medicaid spending will

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[8] *Id*. at 29.

[9] *Id*.

increase only 1.4 percent, on average, over that same period.[10] In contrast, absent health care reform states would see increased Medicaid enrollment and state spending but without the supplemental federal funding.

III. ARGUMENT

In advancing their federalism claims, plaintiffs ignore the reality that the states and the federal government have been working *together* on health care for decades; the ACA does not mark a dramatic change in this relationship. Rather than being "commandeered" or "coerced," the states remain free, as they always have, to end their voluntary participation in Medicaid. Or the states may choose to continue to partner with the federal government to address this pressing national problem. The ACA does not transgress constitutional limits by offering states this choice. And contrary to plaintiffs' assertions, the minimum coverage provision is a necessary and reasonable part of Congress' overall plan for regulating the national health insurance market. Recognizing Congress' authority to regulate in an area of exceptional importance to the national economy is hardly the equivalent of endorsing a general federal police power.

A. The ACA builds on principles of cooperative federalism and dual sovereignty.

Health care policy is not, and has not been for decades, principally a matter for the states. States' ability to raise revenue is far more limited than the federal government's and state budgets are often highly variable from year to year, making stable funding for

[10] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (2010) *available at*: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf (viewed 11/15/2010).

costly health care programs elusive. States also lack the economies of scale that can be achieved on the national level. Moreover, citizens of one state often obtain health care in another state – in fact, because of regional health care systems, residents of one state may depend upon hospitals or other care providers in a neighboring state for essential services.

For all of these reasons, the states and the federal government have been working together to implement health care policy for at least the last half-century. The states for years have played the role envisioned by Justice Brandeis, as "laborator[ies]" of democracy, experimenting with different approaches to health care policy. *See New State Ice Co. v. Liebmann*, 285 US 262, 311 (1932) (Brandeis, J., dissenting). A cooperative federalist system has fostered these experiments by allowing states to take advantage of Medicaid waiver programs and federal funds to expand access to health care and test different approaches to providing care. Programs adopted by three of the Amici States, Vermont, Oregon and Iowa, are widely recognized as models for parts of the ACA.[11] The ACA continues the tradition of cooperation between the states and the federal government in a way that respects our system of dual sovereignty and that will allow states to continue to be laboratories for democracy.

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[11] For example, Vermont and Iowa have expanded Medicaid eligibility to thousands of low-income residents with incomes as high as 185% of the poverty level, and to children with family incomes up to 300% of the poverty level. Vermont has also created a public-private partnership, Catamount Health, which offers affordable private insurance, with public premium subsidies depending on income, to most Vermonters who lack other insurance.

Oregon enacted the Oregon Health Plan (OHP) which provides a basic benefit package built upon a managed care delivery system with integrated mental, physical, and dental health care services. Last year, Oregon's legislature enacted laws expanding insurance coverage to children and low-income adults and establishing of a health insurance exchange.

B. The ACA will help states control spending and expand the Medicaid program and neither commandeers nor coerces them.

The Medicaid program was established forty-five years ago "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Schweiker v. Hogan*, 457 US 569, 572 (1982) (quotation omitted). State participation in Medicaid has always been, and remains, a matter of political choice for each state. *See, e.g., Wilder v. Virginia Hosp. Ass'n*, 496 US 498, 502 (1990) (Medicaid is a "cooperative federal-state program" for which state participation is "voluntary"); *Fla. Ass'n of Rehab. Facilities v. Florida*, 225 F3d 1208, 1211 (11th Cir. 2000) ("No state is obligated to participate in the Medicaid program."). As health care costs have skyrocketed, the Medicaid program has expanded and the federal government's role has become critical in ensuring that the most vulnerable and needy Americans have access to health care. Plaintiffs seize on this fact as a vehicle for a novel theory of unconstitutionality: that because this federally funded program is successful, popular, and an important part of the national health care system, Congress is powerless to expand it. Plaintiffs' argument on this point is unpersuasive and, more to the point for the Amici States, does nothing to further a reasonable understanding of federalism.

Plaintiffs try to turn their voluntary participation in Medicaid into an involuntary and unconstitutional mandate by saying that, as a practical matter, they cannot stop participating in a program that provides medical coverage for millions of their residents. (Am. Compl. ¶ 66, 86.) As detailed in defendants' Memorandum in Support of their Motion for Summary Judgment, this claim finds no support in Supreme Court precedent. *See* ECF No. 82-1 at 41-50. Indeed, Congress may "hold out incentives to the states as a

method of influencing a state's policy choices" through a "variety of methods, short of outright coercion***," *New York v. United States*, 505 US 144, 166 (1992), and pursuant to its spending power, "'Congress may attach conditions on the receipt of federal funds.'" *Id*. at 167 (quoting *South Dakota v. Dole*, 483 US 203, 206 (1987)).

The states' flexibility in designing Medicaid programs has always been cabined by significant federal restrictions, and the states for decades have had the same political choice that states face now: accept federal funding and comply with federal standards, or stop participating in Medicaid. *See, e.g., Wilder*, 496 US at 502 ("participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary"). The fact that Florida and the other plaintiff states are unwilling to give up the substantial benefits they receive through participation in Medicaid does not allow those states to block the expansion of the program by Congress. "'If a State wishes to receive any federal funding, it must accept the related, unambiguous conditions in their entirety.'" *Benning v. Georgia*, 391 F3d 1299, 1308 (11th Cir. 2004) (quoting *Charles v. Verhagen*, 348 F3d 601 (7th Cir. 2003)).

The theory of unconstitutional coercion advanced by plaintiffs is not only unprecedented, but also gravely flawed. Plaintiffs' position is inconsistent with federalism, certain to draw the courts into inherently political disputes, and fundamentally undemocratic.

First, plaintiffs' theory is inconsistent with federalism. By seeking to block the expansion of Medicaid coverage, plaintiffs are trying to achieve their policy preferences through litigation at the expense of states that want Medicaid expanded and that worked

through the democratic process to achieve that policy goal at the national level. While plaintiffs depict this litigation as an issue of states' rights versus the federal government, that perspective is unreasonably narrow. The availability of federal funding for expanded Medicaid coverage is a critical issue for *all* fifty states, and was a matter of substantial and serious democratic debate. Plaintiffs have not explained why their objections should serve as a constitutional barrier to program changes that other states want.

The Amici States are sensitive to claims that the Federal Government has overstepped its authority and take seriously their obligation to protect our federalist system of dual sovereignty. The expansion of the Medicaid program, however, bears none of the hallmarks of federal action that could plausibly be deemed coercive. Congress is not using the power of the federal purse to force unrelated changes in state or local policy, *see Dole*, 483 US at 213-14 (O'Connor, J., dissenting), nor is Congress forcing states to give up constitutional prerogatives in exchange for engaging in lawful activity. *See College Savings Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 US 666, 687 (1999). And contrary to plaintiffs' claims, expanding Medicaid to cover more needy Americans has not fundamentally changed Medicaid. To suggest, as the plaintiffs do, that Medicaid will no longer be a program for the poor, *see* Pls.' Mem. 26, ECF No. 80-1, shows a lack of understanding of the pressing financial needs of many Americans, including the working poor. A family of four with income around $30,000[12] simply cannot afford to purchase insurance on the private market.

[12] The 2010 Federal Poverty Level for a family of four is $22,050. Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010, 75 Fed. Reg. 45628, 45629 (Aug. 3, 2010). 133% of that figure is $29,326.

Given the increasing costs of health care, increasing numbers of uninsured Americans and decades of debate, plaintiffs cannot reasonably claim that they could not foresee this broadening of Medicaid eligibility. *See id.* at 37. Crucially, too, the federal government has not asked the states to "walk off a cliff" or accept "crushing new costs." *Id.* at 27, 35. Under the ACA, the federal government will for three years assume 100% of the cost of expanding eligibility, that amount declining to 90% at the end of the decade. ACA § 2001(a)(3)(B); Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) § 1201. In the end, plaintiffs' claim of coercion proves too much. Indeed, under plaintiffs' theory, Medicaid in its previous form would be deemed unconstitutional because the states were equally unwilling to give up that program. And, ironically, plaintiffs' approach to coercion means that, if Congress provides generous funding for a valuable program (as it has with Medicaid expansion), the program is more likely to be deemed unconstitutional.

Second, plaintiffs' theory would draw the courts into inherently political disputes. Not surprisingly, plaintiffs are unable to provide the Court with any legal principles that could guide this Court or future courts in applying their novel theory of coercion. No guideposts exist for a court to evaluate what types of programs or what level of funding makes a Spending Clause program unconstitutional. While plaintiffs claim that they are not advocating for Medicaid to be "frozen," they have not even attempted to set forth a principled distinction between permissible and impermissible changes. Nor have plaintiffs suggested any way for a court to make these kinds of determinations on a national level. Particularly in hard times, some state budgets are so strapped that a state

may be, as a practical matter, unable to give up any federal funding. In better times, when tax revenues are higher, some states may have fewer constraints. Yet surely the constitutional analysis cannot change from year-to-year or from state-to-state. If plaintiffs' argument is accepted, courts inevitably will be drawn into inherently political matters, such as questions of appropriate levels of taxation, spending, and governance, which are not susceptible to judicial resolution. The Court should not take this step.

Third, plaintiffs' argument is also fundamentally undemocratic. The people of the United States, through their elected representatives, voted to expand the Medicaid program. At some point, the voters may insist that the program be cut or they may support an even broader expansion. Plaintiffs are trying to block these democratic changes to a program that, they admit, represents a substantial portion of federal spending. *See* Pls.' Mem. 26, ECF No. 80-1. To suggest that the national electorate is constitutionally blocked from deciding the terms on which 7% of the federal budget is spent is extraordinary. This is, perhaps, the most serious flaw in plaintiffs' argument. Even assuming that plaintiffs are correct, and most states effectively cannot withdraw from Medicaid because of the program's importance, it does not logically follow that the federal government's design and funding of Medicaid should be held hostage to the views and policy preferences of a minority of individual states. Medicaid is one of the major pieces of the national health care system. It cannot be frozen in time, and while plaintiffs claim that is not their goal it is the necessary result of their argument.

Plaintiffs paint a picture of Medicaid as an essential government service, a program necessary to the health and welfare of many Americans, and a program the states are

unable or unwilling to fund themselves. *E.g.*, Pls.' Mem. 33-35 ECF No. 80-1. All of those factors weigh decisively in favor of letting the democratic process, not individual states and not the courts, determine the scope and requirements of the program. Allowing the plaintiffs to essentially "veto" the expansion of health insurance through Medicaid is not only contrary to federalist principles, it undermines democratic decision-making.

C. The minimum coverage provision is an essential ingredient of the ACA's overall regulation of the health insurance market, and easily falls within the limits of the Commerce Clause power.

At the same that plaintiffs acknowledge the indispensable federal role in providing health insurance coverage to millions of their residents through Medicaid, plaintiffs advance the unpersuasive claim that Congress has exceeded its authority by regulating the health insurance market. This sharp disconnect between plaintiffs' two claims illustrates well the central weakness in their Commerce Clause argument. Plaintiffs have lost sight of the principal concern that animates the Supreme Court's Commerce Clause jurisprudence, namely, ensuring a meaningful distinction between what is truly national and what is truly local.

For decades the provision of health care and the regulation of health care insurance has been a national economic concern. The federal government itself either funds or provides health insurance for a substantial portion of Americans through Medicare, Medicaid, the military and veterans' services, and other programs. It regulates access to insurance for millions more Americans under statutes like ERISA and COBRA. Both health insurance and health care services represent major interstate commercial markets, and no reasonable understanding of the Commerce Clause could limit Congress'

authority to regulate them. For this reason, plaintiffs' focus on the individual mandate in isolation and on the lack of commercial activity of hypothetical individuals is misplaced.

As fully briefed by the defendants, Defs.' Mem. 12-16 ECF No. 82-1, in determining whether the ACA comes within Congress' Commerce Clause power, the Court "need not determine whether *** [the regulated activities] taken in the aggregate, substantially affect interstate commerce in fact, *but only whether a 'rational basis' exists for so concluding*." *Gonzales v. Raich*, 545 US 1, 22 (2005) (emphasis added). And Congress' judgment that an activity would undermine the statutory scheme "is entitled to a strong presumption of validity." *Id.* at 28. The ACA's minimum coverage provision, viewed as a necessary element of Congress' plan to expand access to affordable health insurance, easily fits within the Commerce Clause power.

Rather than repeating the persuasive arguments advanced by defendants, the Amici States instead seek to counter plaintiffs' claim that upholding the ACA is tantamount to recognizing a general federal police power. This claim weakens, rather than strengthens, plaintiffs' argument as the health care market is a textbook case for federal regulation under the Commerce Clause as more than 17% of the United States economy, $2.5 trillion in spending annually, is devoted to health care. ACA § 1501(a)(2)(B). The minimum coverage provision is simply an ingredient of Congress' comprehensive and constitutionally permissible regulation of the interstate health insurance market.

The Amici States, as employers and regulators of health insurance, understand well the problems created when people voluntarily forego purchasing insurance. When purchasing insurance is purely voluntary, people with higher than average health risks

will disproportionately enroll in insurance plans as an individual is more likely to purchase insurance when they expect to require health care services. This phenomenon, referred to as "adverse selection," raises the cost of insurance premiums for two reasons: First, because it tends to create insurance pools with higher-than-average risks, causing insurers to raise premiums, and second, because insurers often add an extra loading fee to their premiums because they anticipate that those with non-obvious health risks are disproportionately obtaining insurance.[13] The minimum coverage provision addresses both of these concerns by moving low-risk people into the risk pool, thus reducing average costs, and by lessening the probability that a given individual is purchasing insurance solely because he or she is ill.

Another consequence of adverse selection is that it decreases access to health insurance for high risk individuals as insurers enact a variety of practices designed to keep high-risk individuals out of their plans and limit the financial cost to the plan if those individuals enroll.[14] The ACA seeks to eliminate many of these practices, and thereby increase access to health coverage, through reforms such as outlawing preexisting condition exclusions and requiring insurers to issue policies to anyone that applies. But

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[13] ACA § 1501(a)(2)(J); Linda J. Blumberg & John Holahan, *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues* (2008) *available at*: http://www.urban.org/uploadedpdf/411603_individual_ mandates.pdf (viewed 11/15/2010); Katherine Swartz, *Reinsuring Health: Why More Middle-Class People are Uninsured, and What the Government Can Do* 51-54, Russel Sage Found (2006).

[14] ACA § 1501(a)(2)(F); *Addressing Adverse Selection in Private Health Insurance Markets*, before Congress of the United States Joint Economic Committee, 108th Congress (2004) (statement of Linda J. Blumberg, Senior Research Associate, Urban Institute) available at: http://www.urban.org/publications/900752.html (viewed 11/18/2010); Mark Merlis, Health Policy Brief Individual Mandate Health Affairs 4-5 (2010) available at: http://www.rwjf.org/files/research/54508.pdf (viewed 11/15/2010).

such reforms are not feasible unless the insurance pool is expanded through a minimum coverage provision.

By expanding coverage, the minimum coverage provision also addresses the national economic burden caused by the cost of uninsured care. Although researchers disagree on the price tag for uncompensated care, it is generally agreed that the cost is substantial representing tens of billions of dollars each year.[15] These costs are magnified because the uninsured frequently delay seeking care, making their medical problems more costly to treat, and the uninsured often seek care in emergency rooms where treatment is expensive and inefficient.[17] Individuals who choose to forego insurance have other impacts on the national economy including lost productivity due to poor health and personal bankruptcies due to health care costs. ACA § 1501(a)(2). In the aggregate, these economic decisions regarding how to pay for health care services including, in particular, decisions to forego coverage and to pay later or, if need be, to depend on free care, have a substantial effect on the interstate health care market as the costs of providing care to the uninsured are passed on to everyone else through higher premiums of on average over $1,000 a year, and higher health care costs. *Id.* § 1501(a)(2)(F).

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[15] *See, e.g.*, Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. Med. & Ethics 397, 402 (2004); Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage? California's Recent Failed Experiment*, 18 S. Cal. Interdisc. L.J. 485, 499 (2009).

[17] *Id.*, Wolman & Miller, 32 J.L. Med. & Ethics at 400; Channick 18 S. Cal. Interdisc. L.J. at 495.

While reasonable people may disagree about the wisdom of a particular national policy,[18] Congress' authority to address the healthcare crisis is entirely consistent with our federalist system of government. Comprehensive regulation of the health insurance market is at the "opposite end of the regulatory spectrum" from the laws invalidated in *United States v. Lopez*, 514 US 549 (1995) and *United States v. Morrison*, 529 US 598 (2000). *See Gonzales v. Raich*, 545 US at 24. Upholding this law will not create a precedent for broad federal intervention into matters of state and local governance.[19]

IV. CONCLUSION

The ACA adheres to the principles of federalism and is well within the power of Congress to enact. The Court should grant defendants' motion for summary judgment.

November 19, 2010

Respectfully submitted,

John Kroger
Oregon Attorney General

/s/ Keith S. Dubanevich
KEITH S. DUBANEVICH
FLND Bar Admission Date: 6/07/2010

[18] Plaintiffs' argument on this point, like their coercion argument, suggests an unjustified lack of trust in the democratic process as a check on federal power. In reality, Congress' authority under the Commerce Clause is very broad, and existing Supreme Court precedent would allow Congress to greatly expand the federal regulatory role in a wide variety of contexts. While the Commerce Clause power does have judicially enforceable limits, the principal limit on Congress lies with the voters. *See, e.g., Gonzales*, 545 US at 25 n. 34 (recognizing the "political checks" that serve to "curb Congress' power).

[19] Perhaps in recognition of the weakness of their "states' rights" argument, plaintiffs also seem to suggest that the minimum coverage provision infringes individual rights. This Court has correctly rejected plaintiffs' substantive due process claim and should not permit its reinsertion through the back door.

Oregon State Bar No. 975200
Chief of Staff and Special Counsel
Oregon Department of Justice
1162 Court Street NE
Salem, OR 97301-4096
Telephone: (503) 378-6002
Facsimile: (503) 378-4017
Email: keith.dubanevich@doj.state.or.us

Tom Miller
Iowa Attorney General
Mark Schantz
Iowa State Bar No. 4893
Solicitor General
Iowa Department of Justice
1305 E. Walnut Street
Des Moines, IA 50319
Telephone: (802) 828-3181
Email: Mark.Schantz@iowa.gov

William Sorrell
Vermont Attorney General
Bridget C. Asay
Vermont State Bar No. 3283
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, VT 05609-1001
Telephone: (319) 335-2840
Email: BAsay@atg.state.vt.us

Douglas F. Gansler
Attorney General of Maryland
200 Saint Paul Place
Baltimore, Maryland 21202

Jack Conway
Kentucky Attorney General
700 Capital Ave. Suite 118
Frankfort, KY 40601

2358564.2

CERTIFICATE OF SERVICE

I hereby certify that on November 19, 2010, the foregoing document was filed with the Clerk of Court via the CM/ECF system, causing it to be served on all counsel of record.

/s/ Keith S. Dubanevich
KEITH S. DUBANEVICH
Chief of Staff and Special Counsel
Oregon Department of Justice