IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN FREEDOM LAW CENTER, *et al*., Plaintiffs, -v- BARACK OBAMA, in his official capacity as President of the United States, *et al*., Defendants.	Case No. 1:14-cv-01143-RBW

PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION TO DISMISS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page**

Constitution

Statutes

Regulations

INTRODUCTION

Despite Defendants' best efforts to complicate this matter, Plaintiffs' standing to challenge the executive action at issue, and thus this court's jurisdiction to hear and decide this case, is straightforward.

The purpose of the Affordable Care Act is to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012). However, by executive fiat, President Obama and his executive agencies have licensed prohibited conduct and engaged in a policy-based, non-enforcement of this federal law for an entire category of individuals and organizations subject to the law. Consequently, by altering the clear and unambiguous statutory requirements of the Affordable Care Act with an unconstitutional and illegal executive branch fiat, and thus proclaiming that otherwise-prohibited conduct will not violate the Act, Defendants have harmed law-abiding citizens, including Plaintiffs, and violated the United States Constitution and the Administrative Procedure Act.

Plaintiffs, who *are subject to the Act and suffering a cognizable injury that is "fairly traceable" to Defendants' unlawful executive action*, have standing to challenge that action. As demonstrated further below, Defendants' principal assertion that "Plaintiffs have not alleged any facts to support, much less establish, the requisite causal connection between their claimed injury (higher health insurance premiums) and the Transitional Policy" (Defs.' Mem. of P. & A. in Supp. of Mot. to Dismiss at 15 [Doc. No. 10-1] [hereinafter "Defs.' Mem."]) is not true.[1]

[1] Plaintiffs are not the only ones who understand basic economics and realize that the challenged executive action (the so-called "administrative fix") is causing health insurance premiums to increase. *See e.g.*, http://www.californiahealthline.org/articles/2014/8/14/administrative-fix-for-canceled-exchange-plans-could-raise-premiums (last visited on Oct. 21, 2014) ("Blue Cross and Blue Shield of North Carolina Vice President of Health Policy Barbara Morales Burke said the

Indeed, Defendants completely (and improperly) ignore explicit congressional findings—findings that have been codified and signed into law by President Obama—that demonstrate the harm and the fact that this harm is "fairly traceable" to the illegal conduct at issue.[2] Moreover,

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fix would '*definitely*' increase the insurer's 2015 rates. She added, 'It's a one-time adjustment for what we didn't assume and couldn't have assumed last year before we knew transitional plans were going to be a possibility.") (emphasis added). (Muise Supplemental Decl. ¶ 2, Ex. A at Ex. 1, attached to this response). In fact, to argue otherwise, as Defendants do here, is to ignore basic economic principles, explicit congressional findings, and commonsense.

[2] Defendants appear to argue that standing is synonymous with, or at least equivalent to, tort causation or proximate cause. They are wrong. In this circuit, "[a]t its core, the causation inquiry asks whether 'the agency's actions materially increase[d] the probability of injury." *N.C. Fisheries Ass'n, Inc.*, 518 F. Supp. 2d 62, 83 (D.D.C. 2007) (quoting *Huddy v. F.C.C.*, 236 F.3d 720, 722 (D.C. Cir. 2001)). By way of explication, this court has time and again explained that the connection between the government action and the injury for standing purposes is not equivalent to tort causation. *See, e.g., Nat'l Treasury Emples. Union v. Whipple*, 636 F. Supp. 2d 63, 73 (D.D.C. 2009) ("Traceability examines whether there is a causal connection between the claimed injury and the challenged conduct, that is, whether the asserted injury was the consequence of the defendant's actions. Causation does not require that the challenged action must be the 'sole' or 'proximate' cause of the harm suffered, or even that the action must constitute a 'but-for cause' of the injury. . . . At its core, the causation inquiry asks whether the agency's actions materially increase[d] the probability of injury.") (quotation marks, brackets, and citations omitted); *Nader v. Democratic Nat'l Comm.*, 555 F. Supp. 2d 137, 149-50 (D.D.C. 2008) ("The plaintiffs correctly point out that the 'fairly traceable' standard is not equivalent to a requirement of tort causation."); *Ward v. Caldera*, 138 F. Supp. 2d 1, 7-8 (D.D.C. 2001) (observing that Article III standing rules do not suggest that "one need show that the defendant's conduct was the proximate cause of the alleged injury"); *see also Connecticut v. Am. Elec. Power Co.*, 582 F.3d 309, 346 (2d Cir. 2009), *rev'd on other grounds Am. Elec. Power Co. v. Connecticut*, 131 S. Ct. 2527 (2011), ("[T]he cases are clear that, particularly at the pleading stage, the 'fairly traceable' standard is not equivalent to a requirement of tort causation. . . . Even [after trial], however, courts have pointed out that 'tort-like causation is not required by Article III.'"); *Nova Health Sys. v. Gandy*, 416 F.3d 1149, 1156 (10th Cir. 2005) ("As other courts have noted, Article III's causation requirement demands something less than the concept of proximate cause.") (quotation marks omitted); *Focus on the Family v. Pinellas Suncoast Transit Auth.*, 344 F.3d 1263, 1273 (11th Cir. 2003) ("[I]n evaluating Article III's causation (or 'traceability') requirement, we are concerned with something less than the concept of 'proximate cause.' As we noted in [*Loggerhead Turtle v. City Council*, 148 F.3d 1231, 1251 n.23 (11th Cir. 1998)], 'no authority even remotely suggests that proximate causation applies to the doctrine of standing.'"); *Pitt News v. Fisher*, 215 F.3d 354, 361 n.4 (3d Cir. 2000) ("A party may demonstrate standing to litigate a claim even if they fail to make out a constitutional violation on the merits. There is thus no inconsistency between our holding that the injury to The Pitt News was fairly traceable to the enactment and enforcement of Act 199 for standing purposes, and our

Defendants' fail to cite the relevant case law demonstrating that an economic injury, including an indirect economic injury, is sufficient to confer standing, as in this case.

To begin with and by way of background, there is no dispute that the Affordable Care Act imposes upon "applicable individuals" various regulatory burdens and costs, including penalties for failing to comply with the Act, and Plaintiffs are currently subject to these burdens, costs, and penalties.[3] Thus, there are at least two separate, albeit related, analyses for standing. First, based on the undisputed congressional findings (and fundamental economic principles), by unlawfully reducing the "health insurance risk pool" by illegally exempting certain individuals (and their health care plans), the resulting increased financial costs and burdens to Plaintiffs (and others) who must remain in the "pool" under penalty of federal law have caused them to suffer an economic injury. And second, as a result of the challenged executive action, Defendants have unlawfully exempted some "applicable individuals" (and their plans) from these burdens, resulting in the law being illegally applied in a discriminatory manner.

In sum, Plaintiffs have alleged a personal injury fairly traceable to Defendant's allegedly unlawful conduct and likely to be redressed by the requested relief.[4]

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discussion, *infra*, holding that The Pitt News suffered only an indirect injury that did not amount to a violation of its First Amendment rights on the merits.").

[3] Defendants' flippant use of a crude idiom to claim that Plaintiffs "bark up the wrong tree when they point to § 5000A as a basis for challenging the Transitional Policy" (Defs.' Mem. at 12) is a mischaracterization of the allegations. Plaintiffs "point to" the Constitution and the Administrative Procedure Act as a basis for challenging the unlawful executive action at issue here. The mandate forcing Plaintiffs to purchase and maintain ACA-compliant insurance (insurance that must comply with the various "market reforms") makes clear that Plaintiffs are subject to the regulatory burdens imposed by the government—burdens that are unlawfully increased (thereby causing an economic injury to Plaintiffs) as a result of the challenged executive action.

[4] The requested relief would require the Affordable Care Act to be enforced as passed by Congress in order to "broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums," and "significantly increas[e] health insurance

STATEMENT OF FACTS

I. The Affordable Care Act.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended* by Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("Affordable Care Act" or "ACA"). The Affordable Care Act (euphemistically called "Obamacare") is often described as the President's signature piece of legislation. By enacting the Affordable Care Act, Congress nationalized health care insurance by placing its requirements within federal control. As noted, the purpose of the Act is to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2580.

To accomplish its purpose, the Affordable Care Act requires, *inter alia*, each "applicable individual" to acquire ACA-compliant health insurance—insurance that satisfies the "market reforms" required by the Act. Individuals who fail to do so must pay a "penalty." *See* 26 U.S.C. § 5000A(b)(1).

As Defendants acknowledge, "[i]n order to regulate the types of health insurance policies being offered to the public, the ACA enacted certain 'market reforms,' . . . which "apply across three different markets for health plans: large group, small group, and individual markets." (Defs.' Mem. 2). The Department of Health and Human Services "has authority to impose civil monetary penalties on issuers offering non-compliant policies." (Defs.' Mem. at 3 [citing 42 U.S.C. § 300gg-22(b)(2)]). In fact, the Secretary of the Department of Health and Human Services is *required* to enforce the Affordable Care Act's "market reforms" (42 U.S.C. §§ 300gg, *et seq*.) "insofar as they relate to the issuance, sale, renewal, and offering of health insurance

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coverage and the size of purchasing pools, which will increase economies of scale [and] lower health insurance premiums." 42 U.S.C. § 18091(2)(I) & (J).

coverage in connection with group health plans or individual health insurance coverage . . . .”). 42 U.S.C. 300gg-22(a)(2) (stating that the “Secretary shall enforce”). This is not discretionary.

As set forth explicitly and unambiguously in the Act, the requirement to purchase and maintain ACA-compliant insurance was to take effect on January 1, 2014. 26 U.S.C. § 5000A(a) (“An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.”).

As support for this mandate (*i.e.*, the requirement that all American citizens, with a few narrow and limited *statutory* exceptions, purchase and maintain an ACA-compliant plan), Congress made the following factual findings: “By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, *will* minimize this *adverse selection* and *broaden the health insurance risk pool* to include healthy individuals, *which will lower health insurance premiums*. The *requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold. . . . By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums*.[5] The

[5] While Plaintiffs’ ACA-compliant insurance plan will begin on December 1, 2014, the coverage period is from December 1, 2014, to November 30, 2015. And if Plaintiffs’ plan year began on January 1, 2015, as opposed to December 1, 2014, that would not change the premiums. (Muise Supplemental Decl. ¶ 4 at Ex. 1). Thus, the “size of the purchasing pools” for plans effective in 2015, such as Plaintiffs’ plan, is most certainly affected by the “administrative fix” announced in 2013. (*See also supra* n.1). Consequently, contrary to Defendants’ assertion, “2014” is not “the period in which Plaintiffs’ claim their own premiums will rise.” (Defs.’ Mem. at 16). Moreover, the fact that Blue Cross Blue Shield is not “availing itself” of what amounts to the illegal “Transitional Policy” “and instead is fully complying with all ACA requirements governing the

requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs." 42 U.S.C. § 18091(2)(I) & (J) (emphasis added).

The Act calls the requirement to purchase ACA-compliant insurance "an essential part" of the federal regulation of health insurance and warns that "the absence of the requirement would undercut Federal regulation of the health insurance market." 42 U.S.C. § 18091(2)(H).

Consequently, through the universal and equitable enforcement of the Affordable Care Act, Congress sought to ensure that those who purchase (and, in particular, those who are required to purchase, such as Plaintiff Muise) health insurance pursuant to the Act would directly benefit from "lower health insurance premiums" and not be burdened by the inevitably higher costs associated with purchasing a plan that is compliant with the Act (an "adverse selection" per Congress). Thus, as Congress made explicit and unambiguous in the Act, the universal enforcement of the mandate to purchase and maintain ACA-compliant plans is an ***essential*** component of the Affordable Care Act—and we see why in light of the havoc wreaked by Defendants' unlawful executive action. (*See, e.g., supra* n.1).

Understanding the importance of having a large pool of insured individuals in order for the economics to work, Congress was certain to make explicit and unambiguous in the Act those

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determination of its premium charges" does not mean that the unlawful executive action has had "no effect whatsoever on the determination of, or amount of, such premiums." (Defs.' Mem. at 18). Quite the opposite is true. Defendants' fundamental mistake is that they are looking only at the pool of actual Blue Cross Blue Shield customers and not the pool of insured. Per Congress' explicit findings, by forcing all "applicable individuals" (the larger pool) to be covered by an ACA-compliant plan (whether purchased directly or through an employer, for example), the pool of those who were required to have such plans (the only plans that Blue Cross Blue Shield will provide) would increase, thereby increasing Blue Cross Blue Shield's customer pool and thus lowering premiums per Congress' findings. However, by executive fiat, Defendants have unlawfully reduced that pool in Michigan (and thus Blue Cross Blue Shield's customer pool), resulting in a dramatic increase (over 57% for Plaintiffs) in the premiums of those (like Plaintiffs) who abide by the law and purchase compliant insurance plans.

few, *limited* categories of individuals who were exempt from the requirement to purchase and maintain an ACA-compliant insurance plan. *See, e.g.*, 26 U.S.C. § 5000A(d)(2)(a)(i) (exempting members of a "recognized religious sect or division" that conscientiously objects to acceptance of public or private insurance funds); § 5000A(d)(2)(a)(ii) (exempting members of a "health care sharing ministry" that meets certain criteria); § 5000A(d)(3) (exempting "[i]ndividuals not lawfully present"); § 5000A(d)(4) (exempting "[i]ncarcerated individuals"). None of these exemptions apply to Plaintiffs. (Compl. ¶ 26 [Doc. No. 1]; Muise Decl. ¶ 29 [Doc. No. 9-1]).

The Affordable Care Act also does not apply to so-called "grandfathered" health care plans. The Act's default position, however, is that an existing health care plan is *not* a grandfathered plan. *See* 42 U.S.C. § 18011(a)(2); 26 C.F.R. § 54.9815-1251T; 29 C.F.R. § 2590.715-1251; 45 C.F.R. § 147.140. Once again, strictly limiting this exemption was necessary to ensure a large risk pool. Plaintiffs' health care plan is not a grandfathered plan under the Affordable Care Act. (Compl. ¶¶ 27-31; Muise Decl. ¶ 9).

II. The Political Fallout Caused by the Affordable Care Act.

In 2013, President Obama promised the American people that "if you like your health care plan, you can keep it." However, this promise was contrary to the purpose and intent of the Affordable Care Act (and thus Congress) as set forth in the Act's clear and unambiguous language. In fact, the Pulitzer Prize winning PolitiFact.com declared President Obama's promise to be the "lie of the year" for 2013. *See* http://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/ (last visited on Oct. 27, 2014); *see also* http://www.whitehouse.gov/health-care-meeting/proposal/titlei/keepit (last visited on Oct. 27, 2014) (stating, "If You Like the Insurance You Have, Keep It"). (Compl. ¶ 28; Muise Decl. ¶ 14).

In October 2013, the Department of Justice filed a brief in this court confirming that "under the grandfathering provision, it is projected that more group health plans will transition to the requirements under the regulations as time goes on. Defendants have estimated that a majority of group health plans will have lost their grandfather status by the end of 2013." Defs.' Mem. in Supp. of Opp'n to Pls.' Mot. for Summ. J. at 27, *Priests for Life v. U.S. Dep't of Health & Human Servs.*, No. 1:13-cv-1261-EGS (D.D.C. Oct. 17, 2013), ECF No. 14-2; *see also* 75 Fed. Reg. 34,538, 34,552-53 (June 17, 2010) (estimating that between 39 percent to 69 percent of "All Employer Plans" would be cancelled by 2013). (Compl. ¶ 29; Muise Decl. ¶ 15).

Thus, as a direct result of the Affordable Care Act, in 2013 millions of Americans received notices that their health insurance was cancelled. This caused a political firestorm because it was contrary to President Obama's public promise to the American people. *See, e.g.*, http://www.politico.com/story/2013/11/obamacare-finally-gets-real-for-america-at-least-35-million-health-insurance-policies-cancelled-99288.html (last visited on Oct. 27, 2014). (Compl. ¶ 31; Muise Decl. ¶¶ 14, 16).

Consequently, as a politically expedient measure, President Obama, through his executive agencies, engaged in a series of executive actions that materially altered the Affordable Care Act without approval from Congress.[6] (Compl. ¶¶ 31-32).

[6] Indeed, Congress began preparing to amend the Affordable Care Act to stop the cancellation of health insurance plans. *See, e.g.*, Keep Your Health Plan Act of 2013, H.R. 3350, 113th Cong. (2013); Keeping the Affordable Care Act Promise Act, S. 1642, 113th Cong. (2013). https://www.congress.gov/bill/113th-congress/house-bill/3350 (last visited Oct. 27, 2014). However, the President threatened to veto this legislation. *See* Office of Mgmt. & Budget, Executive Office of the President, Statement of Administration Policy, H.R. 3350—Keep Your Health Plan Act of 2013 (Nov. 14, 2013) (Muise Supplemental Decl. ¶ 3, Ex. B, at Ex. 1).

III. Defendants' Unlawful Executive Action.

By executive fiat, Defendants altered the requirements of the Affordable Care Act and thus proclaimed by way of an unconstitutional and illegal claim of executive authority that otherwise-prohibited conduct—in particular, providing or maintaining a *non-compliant* health care plan—would *not* violate the Act. (Compl. ¶ 33).

In November 2013, and in response to the political fallout associated with the cancellation of health insurance for millions of Americans, President Obama announced a "transitional policy" that would allow millions of Americans whose insurance companies cancelled their health care coverage to remain in their non-compliant plans contrary to the express and unambiguous language, purpose, and intent of the Act. (Compl. ¶ 34; Muise Decl. ¶ 19, Ex. A).

President Obama's unlawful "transitional policy" was detailed in a November 14, 2013, letter sent to state insurance commissioners by the Director of the Center for Consumer Information and Insurance Oversight, which is part of the Department of Health and Human Services. Through executive fiat, President Obama unilaterally changed the Affordable Care Act by declaring that health insurance policies that were not in compliance with the Act were now in compliance, thereby effectively repealing the Affordable Care Act for millions of Americans, but not for others, including Plaintiffs. (Compl. ¶ 35; Muise Decl. ¶¶ 19-22, Ex. A).

In this letter, President Obama, through his executive agency, the Department of Health and Human Services, acknowledged that "[s]ome individuals and small businesses with health insurance coverage have been notified by their health insurance issuers that their coverage will soon be terminated. We understand that, in some cases, the health insurance issuer is terminating or cancelling such coverage because it would not comply with certain market reforms that are

scheduled to take effect for plan or policy years starting on or after January 1, 2014"—"market reforms" mandated by the Affordable Care Act. Consequently, by executive fiat and contrary to the express and unambiguous language of the Act, Defendants authorized "health insurance issuers . . . to continue coverage that would otherwise be terminated or cancelled" for failing to comply with the Act and further permitted, without authority and contrary to the Act, "affected individuals and small businesses . . . to re-enroll in such coverage." (Compl. ¶ 36; Muise Decl. ¶¶ 20-21, Ex. A).

The letter further states that "[u]nder this transitional policy, health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, and associated group health plans of small businesses, will not be considered out of compliance" with the Affordable Care Act in direct contravention to the clear and unambiguous language of the Act. The letter also states that "[w]e will consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe." (Compl. ¶ 36; Muise Decl. ¶ 22, Ex. A).

On December 19, 2013, the Department of Health and Human Services, through the Center for Consumer Information and Insurance Oversight, issued another directive that is contrary to the clear and unambiguous language of the Affordable Care Act. This directive, which is separate from the unlawful "transitional policy,"[7] provides a further exemption from the penalty for not having health insurance for consumers whose policies will not be renewed because they do not comply with the Act. This directive states, in relevant part, that "[i]f you have been notified that your policy will not be renewed, you will be eligible for a hardship

[7] While this is a separate directive, its purpose and effect is essentially the same as the "transitional policy": it unlawfully exempts and thus removes from the insurance risk pool individuals who would otherwise be required by the Act to be part of this pool, thereby disrupting the economies of scale that Congress intended to make health insurance "affordable."

exemption and will be able to enroll in catastrophic coverage. If you believe that the plan options available in the Marketplace in your area are more expensive than your cancelled health insurance policy, you will be eligible for catastrophic coverage if it is available in your area. In order to purchase this catastrophic coverage, you need to complete a hardship exemption form, and indicate that your current health insurance policy is being cancelled and you consider other available policies unaffordable." To take advantage of this unlawful policy, an insured must "submit the following items to an issuer offering catastrophic coverage in your area: (1) the hardship exemption form; and (2) supporting documentation indicating that your previous policy was cancelled." (Compl. ¶ 37; Muise Decl. ¶¶ 23, 24, Ex. B).

On March 5, 2014, the Director of the Center for Consumer Information and Insurance Oversight confirmed the "transitional policy" previously announced by President Obama. Moreover, in this letter, the Director stated, "We have considered the impact of the transitional policy and will extend our transitional policy for two years—to policy years beginning on or before October 1, 2016, in the small group and individual markets." The letter concludes by stating, "On December 19, 2013, CMS issued guidance indicating that individuals whose policies are cancelled because the coverage is not compliant with the Affordable Care Act qualify for a hardship exemption if they find other options to be more expensive, and are able to purchase catastrophic coverage. This hardship exemption will continue to be available until October 1, 2016, for those individuals whose non-compliant coverage is cancelled and who meet the requirements specified in the guidance." Thus, Defendants have extended their unlawful revisions and modifications of the Act to 2016. (Compl. ¶ 38; Muise Decl. ¶¶ 25-27, Ex. C).

IV. Harm to Plaintiffs.

Plaintiff AFLC is a nonprofit corporation that has offices in Arizona, California, Michigan, New York, and Washington, D.C. It is recognized by the Internal Revenue Service (IRS) as a 501(c)(3) organization. The mission of AFLC is "to fight for faith and freedom through litigation, education, and public policy programs." To promote its mission, AFLC prosecutes cases to, *inter alia*, advance and defend religious liberty, freedom of speech, and the sanctity of human life, and it crafts litigation to promote a limited government and a renewed federalism, which are necessary to protect and preserve freedom. (Compl. ¶¶ 10-11; Muise Decl. ¶¶ 3, 4).

Plaintiff Muise is Co-Founder and Senior Counsel of AFLC. He is a resident of Michigan, and he receives health insurance for himself and his family through AFLC. (Compl. ¶ 12; Muise Decl. ¶ 2).

As part of its religious commitment grounded in Judeo-Christian social teaching, AFLC promotes the physical and spiritual health and well-being of its employees. As part of this commitment, AFLC ensures that its employees and their families have health insurance. (Compl. ¶ 41; Muise Decl. ¶ 5).

AFLC provides health insurance to Plaintiff Muise via a group plan purchased through Blue Cross Blue Shield of Michigan. Plaintiff Muise makes monthly contributions to help subsidize the costly health care plan purchased by AFLC. AFLC's next plan year will commence on December 1, 2014. (Compl. ¶¶ 42, 43; Muise Decl. ¶ 6).

AFLC provides its employees with health insurance that is compliant with the Affordable Care Act as passed by Congress. By doing so, AFLC ensures that its employees are abiding by the law and will not be subject to penalty for failing to have an ACA-compliant plan. Plaintiff

Muise satisfies this requirement by having insurance through AFLC, which provides an "eligible employer-sponsored plan." 26 U.S.C. § 5000A(f)(1)(B). (Compl. ¶ 44; Muise Decl. ¶¶ 7, 8, 12).

AFLC's health care plan is and will continue to be compliant with the Affordable Care Act. Because of the Act and Plaintiffs' desire and intention to abide by lawfully-enacted federal law, AFLC's health insurance premiums and thus Plaintiff Muise's contribution to those premiums are higher than if they were permitted to choose their own, non-compliant health care plan. Thus, providing ACA-compliant insurance is imposing a financial burden upon, and thus a direct economic injury to, Plaintiffs. (Compl. ¶ 45; Muise Decl. ¶¶ 7, 12]).

For the health insurance plan providing coverage from December 1, 2013 to November 30, 2014, AFLC paid a monthly premium of $1,349.96 for Plaintiff Muise's health insurance plan. Plaintiff Muise contributed $600 per month to that premium. For the plan that will provide coverage from December 1, 2014 to November 30, 2015, the monthly premium for Plaintiff Muise's health plan—a plan which is comparable to the earlier plan—will increase to $2,121.59. That is a monthly increase of $771.63 or a 57 percent cost increase.[8] As a result, Plaintiff Muise's contribution to the premium will also similarly increase by approximately 57 percent. (Muise Decl. ¶ 13 n.2).

[8] Despite this significant increase in Plaintiffs' costs, according to the White House, "Health care price inflation is at its lowest rate in 50 years. Recent years have also seen exceptionally slow growth in the growth of prices in the health care sector, in addition to total spending. Measured using personal consumption expenditure price indices, health care inflation is currently running at just 1 percent on a year-over-year basis, the lowest level since January 1962. (Health care inflation measured using the medical CPI is at levels not seen since September 1972.)" http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf (last visited Oct. 30, 2014). Thus, the 57 percent cost increase cannot be attributed to inflation. (Muise Decl. ¶ 13 n.1). And in light of the congressional findings, these increases are "fairly traceable" to the fact that Defendants have improperly reduced the insurance risk pools via unlawful executive action, resulting in harm to Plaintiffs.

Congress' explicit findings make clear that as the pool of "applicable individuals" who are required to purchase ACA-compliant plans is reduced, as Defendants have done through unlawful executive action, the direct effect of this action is to financially burden those who do purchase such plans, specifically including Plaintiffs, who are now suffering an economic injury directly related to Defendants' unlawful actions. (Compl. ¶ 46; Muise Decl. ¶ 11).

AFLC has no legal basis for terminating Plaintiff Muise's health care plan. As a law-abiding organization, AFLC will comply with the law as passed by Congress (which, apparently, is also the view of Blue Cross Blue Shield of Michigan). To be eligible for the so-called "transitional policy," which Defendants unlawfully created via executive action, Plaintiffs would have to make materially false statements to the government, which they cannot and will not do. (Compl. ¶ 47; Muise Decl. ¶ 28).

If AFLC terminated Plaintiff Muise's health care plan, Plaintiff Muise would be required to purchase a costly individual plan or else he would be subject to penalty, which, as a law-abiding citizen, he would pay. Plaintiff Muise is not qualified for any exemption from the penalty. (Compl. ¶ 48; Muise Decl. ¶ 29).

Michigan is one of the states in which non-compliant health insurance plans (*i.e.*, plans that are unlawful under the clear and unambiguous language of the Affordable Care Act) are permitted pursuant to the President's "transitional policy," but only so long as the health care insurer is willing and able to provide such plans. (Muise Decl. ¶ 30, Ex. D).

Thus, as a result of Defendants' unlawful executive action, Michigan is a state in which the "health insurance risk pool" has been narrowed, contrary to Congress' explicit findings and intent, thereby increasing (rather than reducing) "administrative costs" and "health insurance premiums." As a result, Plaintiffs' health insurance premium (and thus costs) increased by 57

percent. (Muise Decl. ¶ 31).

AFLC's health insurance provider, Blue Cross Blue Shield of Michigan, is only providing health insurance plans that are "compliant with federal requirements." (Muise Decl. ¶ 32, Ex. E).

Because Defendants' directives, which permit some individuals and small businesses to maintain non-compliant health care plans in 2014 and beyond without being subject to penalty, are unlawful, Plaintiffs cannot and will not go along with this *ultra vires* executive action, resulting in higher costs for Plaintiffs and thereby causing an economic injury as a direct result of Defendants' failure to "faithfully execute" the Affordable Care Act. (Compl. ¶¶ 49-51; Muise Decl. ¶ 33).

ARGUMENT

I. LEGAL BASIS FOR CLAIMS.

We begin our standing analysis with a brief discussion of the legal justification for advancing a "separation of powers claim" on behalf of an individual.[9] As the Supreme Court affirmed in *Bond v. United States*, 131 S. Ct. 2355 (2011):

> Separation-of-powers principles are intended, in part, to protect each branch of government from incursion by the others. Yet the dynamic between and among the branches is not the only object of the Constitution's concern. The structural principles secured by the separation of powers protect the individual as well. . . . In the precedents of this Court, *the claims of individuals*—not of Government departments—have been the principal source of judicial decisions concerning separation of powers and checks and balances.

[9] There is no question that a party may advance an equal protection challenge to a law that unlawfully discriminates, including discrimination that causes economic burdens, *see Gen. Motors Corp. v. Tracy*, 519 U.S. 278 (1997) (permitting a party to challenge a state's tax classifications under the Equal Protection Clause), or disparate economic benefits, *see Zobel v. Williams*, 457 U.S. 55, 65 (1982) (holding that Alaska's dividend distribution plan which favored some residents over others violated equal protection).

Id. at 2365 (emphasis added). The Supreme Court recently made the following relevant observation in *NLRB v. Noel Canning*, 134 S. Ct. 2550 (2014):

> We recognize, of course, that the separation of powers can serve to safeguard individual liberty, *Clinton v. City of New York*, 524 U. S. 417, 449-50 (1998) (KENNEDY, J., concurring), and that it is "*the duty of the judicial department*"—in a separation-of-powers case as in any other—"*to say what the law is*," *Marbury v. Madison*, 1 Cranch 137, 177 (1803).

Noel Canning, 134 S. Ct. at 2559-60 (emphasis added).

In sum, Plaintiffs' legal claims are justified under controlling law, and it is "the duty of [this court] to say what the law is."

II. PLAINTIFFS HAVE STANDING TO ASSERT THEIR CLAIMS.

A. Plaintiffs' Claims Present a "Case" or "Controversy" under Article III.

Having established the legal justification for the claims at issue, we now proceed to explain why Plaintiffs have standing to make the claims. To begin with, it is axiomatic that Article III of the Constitution confines the federal courts to adjudicating actual "cases" or "controversies." U.S. Const. art. III, § 2. As stated by the Supreme Court:

> A justiciable controversy is . . . distinguished from a difference or dispute of a hypothetical or abstract character; from one that is academic or moot. The controversy must be definite and concrete, touching the legal relations of parties having adverse legal interests. It must be a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion advising what the law would be upon a hypothetical state of facts. Where there is such a concrete case admitting of an immediate and definite determination of the legal rights of the parties in an adversary proceeding upon the facts alleged, the judicial function may be appropriately exercised . . . .

Aetna Life Ins. Co. v. Haworth, 300 U.S. 227, 240-41 (1937) (citations omitted).

Here, there is nothing "hypothetical," "abstract," "academic," or "moot" about the legal claims advanced. This case presents "a real and substantial controversy" between parties with "adverse legal interests," and this controversy can be resolved "through a decree of a conclusive

character." *Id*. It will not require the court to render "an opinion advising what the law would be upon a hypothetical state of facts." *Id*. In sum, it presents a "justiciable controversy" in which "the judicial function may be appropriately exercised." *Id.*

B. Plaintiffs Have Asserted an "Injury-in-Fact" that Is "Fairly Traceable" to the Challenged Executive Action and "Likely To Be Redressed by the Requested Relief."

In an effort to give meaning to Article III's "case" or "controversy" requirement, the courts have developed several justiciability doctrines, including standing. *See Susan B. Anthony List v. Driehaus,* 134 S. Ct. 2334, 2341 (2014). "The doctrine of standing gives meaning to these constitutional limits by identifying those disputes which are appropriately resolved through the judicial process." *Id.* (internal quotations and citation omitted).

"In essence the question of standing is whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues." *Warth v. Seldin*, 422 U.S. 490, 498 (1975). Consequently, to invoke the jurisdiction of a federal court, "[a] plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen v. Wright*, 468 U.S. 737, 751 (1984). While the necessary injury-in-fact to confer standing is not susceptible to precise definition, it must be "distinct and palpable," *Warth*, 422 U.S. at 501, and not merely "abstract," "conjectural," or "hypothetical," *Allen*, 468 U.S. at 751. Put another way, the injury must be both "concrete and particularized," meaning "that the injury must affect the plaintiff in a *personal* and *individual* way."[10] *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (emphasis added).

[10] Defendants' incorrectly assert the following: "But Plaintiffs cannot establish a personal, particularized injury by relying on abstract economic theory, divorced from the particular facts and circumstances of their situation. *See, e.g., Lujan*, 504 U.S. at 563 ("[T]he injury in fact test requires more than an injury to a cognizable interest. It requires that the party seeking review be

To that end, courts have recognized that "[a]n economic injury which is traceable to the challenged action satisfies the requirements of Article III." *Linton v. Commissioner of Health & Env't*, 973 F.2d 1311, 1316 (6th Cir. 1992); *see also Gen. Motors Corp. v. Tracy*, 519 U.S. 278 (1997) (holding that consumers who suffer economic injury from a regulation prohibited under the Constitution satisfy the standing requirement); *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.*, 528 U.S. 167, 184 (2000) (acknowledging that regulations injuring a plaintiff's "economic interests" create the necessary injury-in-fact to confer standing); *see also Jet Courier Services, Inc. v. Fed. Reserve Bank*, 713 F.2d 1221, 1226 (6th Cir. 1983) ("Here, if the affidavits of customers of the air couriers are credited, these couriers *will suffer economic losses flowing from actions which the private banks will take in response to the revised schedules of the Federal Reserve Banks*. Though the injury alleged by the plaintiffs is indirect, it is 'distinct and palpable' and 'fairly traceable' to the action of the Board of Governors. . . . We believe the plaintiffs have sufficiently alleged a 'personal stake,' . . . in the outcome of the controversy and have demonstrated a likelihood that their injury would be redressed by a favorable decision. Thus they have satisfied the constitutional requirements for standing.") (emphasis added).

In *General Motors Corp. v. Tracy*, 519 U.S. 278 (1997), for example, the Supreme Court "granted GMC's petition for certiorari to address the question of standing as well as the Commerce and Equal Protection Clause issues," *id*. at 286, involving a challenge to Ohio's general sales and use taxes on natural gas purchases from all sellers, except regulated public utilities that met the statutory definition of a natural gas company. While the Court ultimately held that the discriminatory tax treatment did not violate the Constitution, the Court concluded that GMC had standing to bring this challenge, stating:

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himself among the injured." (quotations omitted, emphasis added))." (Defs.' Mem. at 20). As the facts demonstrate, Plaintiffs are themselves "among the injured." *Lujan*, 504 U.S. at 563.

> The Supreme Court of Ohio held GMC to be without standing to raise this Commerce Clause challenge because the company is not one of the sellers said to suffer discrimination under the challenged tax laws. *But cognizable injury from unconstitutional discrimination against interstate commerce does not stop at members of the class against whom a State ultimately discriminates, and customers of that class may also be injured, as in this case where the customer is liable for payment of the tax and as a result presumably pays more for the gas it gets from out-of-state producers and marketers*. Consumers who suffer this sort of injury from regulation forbidden under the Commerce Clause satisfy the standing requirements of Article III. *See generally Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561 [(1992)].
>
> On similar facts, we held in *Bacchus Imports, Ltd. v. Dias*, 468 U.S. 263 [(1984)], that in-state liquor wholesalers had standing to raise a Commerce Clause challenge to a Hawaii tax regime *exempting certain alcohols produced in-state from liquor taxes*. Although the wholesalers were not among the class of out-of-state liquor producers allegedly burdened by Hawaii's law, we reasoned that the wholesalers suffered economic injury both because they were directly liable for the tax and because *the tax raised the price of their imported goods relative to the exempted in-state beverages*. *Id.*, at 267; *see also Fulton Corp. v. Faulkner*, 516 U.S. 325 [(1996)] (in-state stockholder challenged tax regime imposing higher taxes on stock from issuers with out-of-state operations than on stock from purely in-state issuers); *West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186 [(1994)] (in-state milk dealers challenged tax and subsidy scheme discriminating against out-of-state milk producers). *Bacchus* applies with equal force here, and GMC "plainly has standing to challenge the tax in this Court," *Bacchus Imports v. Dias, supra*, at 267. We therefore turn to the merits.

Gen. Motors Corp. v. Tracy, 519 U.S. at 286-87; *see generally Warth*, 422 U.S. at 504-05 ("The fact that the harm to petitioners may have resulted indirectly does not in itself preclude standing. When a governmental prohibition or restriction imposed on one party causes specific harm to a third party, harm that a constitutional provision or statute was intended to prevent, the indirectness of the injury does not necessarily deprive the person harmed of standing to vindicate his rights."). In short, even indirect economic harm caused by government action is sufficient to satisfy the injury-in-fact requirement necessary to confer standing to challenge the government action at issue. Moreover, where a government-created exemption to a regulation creates a financial burden to a party subject to the regulation, the burdened party has standing to challenge

the lawfulness of that exemption. Thus, under controlling precedent and in light of the facts alleged in this case, Plaintiffs have standing to challenge the unlawful executive actions at issue.

Additionally, courts have routinely found sufficient adversity between the parties to create a justiciable controversy when suit is brought by the particular plaintiff subject to the regulatory burden imposed by a statute, as in this case. *See Doe v. Bolton*, 410 U.S. 179 (1973); *Planned Parenthood Ass'n v. City of Cincinnati*, 822 F.2d 1390, 1394-95 (6th Cir. 1987). Indeed, when the plaintiff is an object of the challenged action "there is ordinarily little question that the action or inaction has caused him injury." *Defenders of Wildlife*, 504 U.S. at 561-62.

On March 23, 2010, the Affordable Care Act was signed into law by President Obama. The Act regulates virtually all Americans, including Plaintiffs, in an *individual* and *personal* way, with few exceptions—and it regulates them now by coercing behavior and compliance *via* regulatory burdens and penalties. The Act *is* federal law—there is no condition precedent necessary, nor is there any subsequent regulation required to make it so. *See Columbia Broad. Sys., Inc. v. United States*, 316 U.S. 407, 418 (1942) (noting that a regulation "sets a standard of conduct for all to whom its terms apply, [and i]t operates as such in advance of the imposition of sanctions upon any particular individual").

Consequently, as of March 23, 2010, Plaintiffs were subject to the regulations set forth in the Affordable Care Act.[11] Pursuant to the Act, Plaintiff Muise is subject to the requirement that he purchase and maintain ACA-compliant health insurance. *See* 26 U.S.C. § 5000A(b)(1). Plaintiff Muise satisfies this "essential component" of the Act by maintaining, through financial

[11] While Plaintiff AFLC is not *required* to provide health care insurance to its employees under the Act since it has less than 50 employees, *because it does so* as part of its commitment to its Judeo-Christian values and to ensure that its employees, such as Plaintiff Muise, comply with the "minimum essential coverage" requirement *via* an employee-sponsored plan, *see* 26 U.S.C. § 5000A(f)(1)(B), *it's policy must comply with the Act*, *see* 26 U.S.C. § 4980D; 42 U.S.C. §§ 300gg, *et seq*.

contribution, an employee-sponsored (and ACA-compliant) health care plan provided by AFLC, which also makes a substantial contribution to the plan. *See* 26 U.S.C. § 5000A(f)(1)(B); (*see also supra* n.11).

By unlawfully granting certain "applicable individuals" an exemption from the law's costly and burdensome requirement to purchase and maintain ACA-compliant insurance—a classification that discriminates against Plaintiffs—Defendants' are imposing greater regulatory burdens and costs on Plaintiffs. Defendants' discrimination, however, is not legitimate because it was based on President Obama's failure to "faithfully execute" the Affordable Care Act and Defendants' unlawful revision of clear statutory terms in violation of the separation of powers set forth in the Constitution. Thus, Defendants' discrimination, which is requiring Plaintiffs to carry a heavier financial burden and thus increasing Plaintiffs' costs, is *per se* unlawful and cannot survive the rational basis test under an equal protection analysis.

As noted previously, Congress made specific findings which are codified in federal law and which demonstrate that Plaintiffs' harm is "fairly traceable" to Defendants' unlawful action:

> By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold. . . . By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

42 U.S.C. § 18091(2)(I) & (J). Requiring the purchase of ACA-compliant insurance, which will then *increase* "the size of purchasing pools," is "an essential part" of the federal regulation of health insurance because "the *absence* of the requirement would undercut Federal regulation of

the health insurance market" and thus significantly *increase* health insurance premiums. *See* 42 U.S.C. §18091(2)(H) (emphasis added). Defendants fail to address these explicit findings, which operate as an admission that Plaintiffs' harm is not "speculative" and that this harm was fully expected and certainly "fairly traceable" to Defendants' unlawful actions. (*See supra* n.2).

Thus, through the equitable enforcement of the Act's central requirement which was designed to increase insurance risk pools, Congress sought to ensure that those who purchase (and, in particular, those who are required to purchase, such as Plaintiff Muise) health insurance pursuant to the Act would directly benefit from "lower health insurance premiums." Because Defendants have illegally thwarted the clear purpose and intent of the Act's regulatory scheme by reducing *via* executive fiat the "health insurance risk pool," the known and expected financial burden for doing so falls directly on those individuals who are required to purchase and maintain ACA-compliant health insurance, such as Plaintiffs. That is, Congress' explicit findings make clear that as the pool of "applicable individuals" who are required to purchase ACA-compliant insurance plans is reduced, as Defendants have done through unlawful executive action, the direct effect of this lawlessness is to financially burden those who abide by the law and thus purchase and maintain compliant plans, specifically including Plaintiffs, who are now suffering an economic injury directly related to Defendants' unlawful action. (*See also supra* n.1).

And in light of these explicit findings (which are grounded in sound economic principles), the requested relief would require Defendants to enforce the Affordable Care Act as passed by Congress so as to "broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums," and "significantly increas[e] health insurance coverage and the size of purchasing pools, which will increase economies of scale

[and] lower health insurance premiums."[12] 42 U.S.C. § 18091(2)(I) & (J). Thus, Congress' findings make clear that Plaintiffs' harm will likely be redressed by the requested relief. To argue otherwise is to essentially argue that by passing the Affordable Care Act the federal government has perpetrated a huge fraud on the American people.[13] But the reality remains that Congress' findings are correct as a matter of basic economic principles. And because they are correct, Plaintiffs have alleged a "personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen*, 468 U.S. at 751.

CONCLUSION

For the foregoing reasons, Plaintiffs hereby request that the court deny Defendants' motion to dismiss.

[12] Consider, for example, *Zobel v. Williams*, 457 U.S. 55 (1982), in which a segment of Alaskan residents challenged on equal protection grounds the constitutionality of a statutory scheme by which the state distributed income derived from natural resources to the adult citizens of Alaska in varying amounts based on the length of each citizen's residence. The Court held that the distribution plan was invalid. However, striking down the plan did not guarantee that the challengers would receive a higher disbursement than if they had not challenged the law. Indeed, the state could have chosen to lower the disbursements so that all recipients received the lowest amount (leaving the challengers in the same position) or it could have chosen not to distribute any income whatsoever (leaving the challengers in a worse position). Nonetheless, the Court exercised its jurisdiction to decide the case and struck down the statute. Here, the injury and the redressability of that injury are far more concrete as evidenced by Congress' explicit findings.

[13] Indeed, Defendants' assertion that the "economic theory" relied upon by Plaintiffs to demonstrate injury "defies common sense" (*see, e.g.,* Defs.' Mem. at 20) is a serious indictment against the "economic theory" that underlies the entire *Affordable* Care Act, Congress' explicit findings to support the Act, and this administration's many promises to the American people regarding the alleged beneficial effects of the Act—in particular, that the Act will result in lower premiums.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 30, 2014, a copy of the foregoing was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties may access this filing through the Court's system. I further certify that a copy of the foregoing has been served by ordinary U.S. mail upon all parties for whom counsel has not yet entered an appearance electronically: none.

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