ORAL ARGUMENT HELD ON APRIL 5, 2016

NO. 15-5164

In the

United States Court of Appeals for the District of Columbia Circuit

AMERICAN FREEDOM LAW CENTER; ROBERT JOSEPH MUISE,
Plaintiffs-Appellants,

v.

BARACK HUSSEIN OBAMA, in his official capacity as President of the United States; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; SYLVIA MATTHEWS BURWELL, in her official capacity as Secretary, U.S. Department of Health & Human Services; UNITED STATES DEPARTMENT OF TREASURY; JACOB J. LEW, in his official capacity as Secretary, U.S. Department of the Treasury; UNITED STATES DEPARTMENT OF LABOR; THOMAS E. PEREZ, in his official capacity as Secretary, U.S. Department of Labor,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
HONORABLE REGGIE B. WALTON
CASE NO. 1:14-cv-01143-RBW

APPELLANTS' PETITION FOR REHEARING EN BANC

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GLOSSARY OF TERMS

ACA	Affordable Care Act
AFLC	American Freedom Law Center
BCBSM	Blue Cross Blue Shield of Michigan

INTRODUCTION AND RULE 35 STATEMENT

This case presents another example of what Circuit Judge Brown described in her concurring opinion in *Arpaio v. Obama*, 797 F.3d 11, 25 (D.C. Cir. 2015) as "our modern obsession with a myopic and constrained notion of standing." *Id.* (Brown, J., concurring). As Judge Brown observed in *Arpaio*—an observation that is relevant here—"Our jurisprudence on standing has many shortcomings. As today's decision demonstrates, standing doctrines often immunize government officials from challenges to allegedly *ultra vires* conduct." *Id.* at 29.

The panel's decision here suffers from this "shortcoming" by effectively immunizing the Executive Branch from this challenge to its *ultra vires* actions.

As Supreme Court precedent demonstrates, "the claims of individuals—not of Government departments—have been the principal source of judicial decisions concerning separation of powers and checks and balances." *Bond v. United States*, 131 S. Ct. 2355, 2365 (2011). When an individual is subject to the burdens of a federal law, including penalties for noncompliance with the law, and the government engages in an *ultra vires* discriminatory enforcement of the law which violates the Constitution, the individual who remains subject to the burdens and punishment of the law has standing to challenge the enforcement action. That is elementary. That is this case.

As set forth in this petition, the panel decision conflicts with standing decisions from the U.S. Supreme Court, *see Gen. Motors Corp. v. Tracy*, 519 U.S. 278 (1997), and with decisions from this Court, *see Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 810 (D.C. Cir. 1983); *Sherley v. Sebelius*, 610 F.3d 69, 73 (D.C. Cir. 2010). Fed. R. App. P. 35(b)(1)(A). Indeed, because Plaintiffs' allegations of injury "are firmly rooted in the basic laws of economics," they have standing to pursue their claims. *United Transp. Union v. Interstate Commerce Comm'n*, 891 F.2d 908, 912 n.7 (D.C. Cir. 1989).

Additionally, as Circuit Judge Brown's concurrence in *Arpaio* demonstrates, this case raises a question of exceptional importance: the application of the standing doctrine in the context of a challenge to *ultra vires* executive action. Fed. R. App. P. 35(b)(1)(B). Here, the challenged executive action is unlawful and a court of law should say so. *NLRB v. Noel Canning*, 134 S. Ct. 2550, 2559-60 (2014) ("[I]t 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)].").

The Court should grant *en banc* review.

SUMMARY OF FACTS

The Affordable Care Act requires each "applicable individual" to purchase and maintain "minimum essential coverage" (*i.e.*, ACA-compliant insurance) or

pay a "penalty." *See* 26 U.S.C. § 5000A(b)(1). This mandate was required to take effect on January 1, 2014. 26 U.S.C. § 5000A(a).

As support for this mandate, Congress made the following 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. 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).

Through the universal and equitable enforcement of the mandate, Congress sought to ensure that those who are required to purchase ACA-compliant health insurance, such as Plaintiff Muise, would benefit from "lower health insurance premiums" and not be burdened by the inevitably higher costs associated with purchasing and maintaining the "minimum essential coverage" required by the Act. (JA 19-20; R-1 [Compl. ¶ 25]).

To ensure public support for his signature piece of legislation, President Obama promised the American people that "if you like your health care plan, you can keep it." However, in 2013 millions of Americans received notices that their

health insurance was cancelled because of the Act, creating a political firestorm. (JA 20-21; R-1 [Compl. ¶¶ 28, 31]).

As a politically expedient measure, President Obama engaged in a series of executive actions that materially altered the Affordable Care Act without approval from Congress. In November 2013, 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 language, purpose, and intent of the Act. Through this policy, Defendants unilaterally authorized "health insurance issuers . . . to continue coverage that would otherwise be terminated or cancelled" for failing to comply with the Act and further permitted "affected individuals and small businesses . . . to re-enroll in such coverage." (*See* JA 21-24; R-1 [Compl. ¶¶ 32-40]). The "transitional policy" was extended to October 1, 2017.[1] (Op. at 4 n.1).

"On December 19, 2013, CMS issued guidance indicating that individuals whose policies are cancelled because the coverage is not compliant with the

[1] The panel asserted that the transitional policy "applies solely to health insurance providers . . . . [It] does not apply to individuals, who still are required to comply with the ACA's individual mandate, unless they qualify for the Hardship Exemption." (Op. at 4). That is incorrect in that an individual who maintains a non-compliant plan pursuant to the transitional policy is not subject to penalty. Otherwise, the policy makes little sense. Maintaining a plan under the "transitional policy" would satisfy the "minimum essential coverage" requirement because the plan is considered an "eligible employer-sponsored plan." 26 U.S.C. § 5000A(f)(1)(B). Indeed, the expressed purpose of the transitional policy is to permit individuals to keep their non-compliant plans.

Affordable Care Act qualify for a hardship exemption if they find other options to be more expensive, and are able to purchase catastrophic coverage." (JA 23; R-1 [Compl. ¶ 37]).

Plaintiff AFLC is a nonprofit corporation. Plaintiff Muise is Co-Founder and Senior Counsel of AFLC and a resident of Michigan. He receives health insurance for himself and his family through AFLC. AFLC provides health insurance to Plaintiff Muise via a group plan purchased through BCBSM. (JA 16-17, 24-25; R-1 [Compl. ¶¶ 10-12, 41-43]).

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 insurance policy that is not compliant with the Act. Plaintiff Muise satisfies the "minimum essential coverage" requirement because AFLC's health care plan is an "eligible employer-sponsored plan." (JA 25; R-1 [Compl. ¶ 44]).

AFLC's health care plan is and will be *compliant* with the law (*i.e.*, the Affordable Care Act). Consequently, it doesn't matter that BCBSM chose to offer only lawful health care plans.[2] Had BCBSM decided otherwise, Plaintiffs would have still chosen a plan that complied with the Act. (*See* JA 25-26; R-1 [Compl. ¶¶

[2] BCBSM has "responded to the new government mandates by creating an entire portfolio of health plan options that are both comprehensive and compliant with federal requirements." (JA 40-41, 59-60; R-9-1 [Muise Decl. ¶ 32, Ex. E]).

45, 49]). Thus, the panel was incorrect when it concluded that "any alleged injury to [Plaintiffs] from the Transitional Policy stemmed not from the Policy itself, which HHS applied evenhandedly, but from Blue Cross's decision not to take advantage of the Policy." (Op. at 2).

Because of the Act and Plaintiffs' desire and intention to abide by lawfully-enacted federal law, AFLC's health insurance premiums are higher than if they chose to purchase an unlawful, non-compliant health care plan. Thus, complying with the "minimum essential coverage" requirement of the Act is imposing a financial burden upon, and thus a direct economic injury to, Plaintiffs. (JA 25-26; R-1 [Compl. ¶¶ 46-49]).

Congress's explicit findings make clear that as the pool of "applicable individuals" who are required to purchase "minimum essential coverage" pursuant to the Affordable Care Act is reduced, as Defendants have done through unlawful executive action, the direct effect is to financially burden those who do maintain "minimum essential coverage," specifically including Plaintiffs, who are now suffering an economic injury directly related to Defendants' unlawful action. (JA 19-20, 25-26; R-1 [Compl. ¶¶ 23-27, 46]).

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 and signed by the President. (JA 26; R-1 [Compl. ¶ 47]).

If AFLC terminated Plaintiff Muise's health care plan, Plaintiff Muise would be required under the Individual Mandate to purchase a costly individual plan or else he would be subject to the mandate's penalty, which, as a law-abiding citizen, he would pay. (JA 26; R-1 [Compl. ¶ 48]).

In addition to the allegations in the Complaint, empirical evidence supports Plaintiffs' standing argument. Based on BCBSM's June 2014 rate filing, and more specifically, based on an actuarial memorandum which was included with the filing, BCBSM's premiums for 2015 did increase based on "[s]ignificant drivers of the rate change," which included "[l]ower than anticipated improvement of the ACA compliant market level risk pool in 2014 and 2015 due to the market being allowed to extend pre-ACA non-grandfathered plans into 2016." (JA 80; R-16-1 [BCBSM 2015 Rate Filing Mem. at 7]).

ARGUMENT

I. The Elements of Standing.

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).

To invoke the court's jurisdiction, "[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).

"Because the district court dismissed this case at the complaint stage, [Plaintiffs] need only make a plausible allegation of facts establishing each element of standing." *Cutler v. U.S. Dep't of Health & Human Servs.*, 797 F.3d 1173, 1179 (D.C. Cir. 2015).

While the necessary injury-in-fact to confer standing is not susceptible to a 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." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, n.1 (1992).

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. Comm'r of Health & Env't*, 973 F.2d 1311, 1316 (6th Cir. 1992); *see also Gen. Motors Corp. v. Tracy*, 519 U.S. 278 (1997); *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.*, 528 U.S. 167, 184 (2000) (injuring a plaintiff's "economic

interests" creates the necessary injury-in-fact). Moreover, "[t]here is . . . no requirement that the injury be important or large; an 'identifiable trifle' can meet the constitutional minimum. The injury need not have already occurred; it is sufficient if it is 'actual' or 'threatened.' And an injury shared by a large number of people is nonetheless an injury." *Ctr. for Auto Safety v. Nat'l Highway Traffic Safety Admin.*, 793 F.2d 1322, 1331 (D.C. Cir. 1986) (finding that consumers suffered sufficient injury in fact to challenge regulations reducing fuel economy standards "because the vehicles available for purchase will likely be less fuel efficient than if the fuel economy standards were more demanding").

"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." *Nat'l Treasury Emps. Union v. Whipple*, 636 F. Supp. 2d 63, 73 (D.D.C. 2009) (quotation marks, brackets, and citations omitted).

Finally, regarding redressability, this Court stated:

> The "fairly traceable" and "redressibility" requirements for Article III standing ensure that the injury is caused by the challenged action and can be remedied by judicial relief. When, as in this case, the relief requested is simply the cessation of illegal conduct, the Court has

> noted that the "fairly traceable" and "redressibility analyses are identical."

Ctr. for Auto Safety, 793 F.2d at 1334. Consequently, because the relief requested here "is simply the cessation of illegal conduct," the fairly traceable and redressibility analyses are "identical." *Id*.

II. Plaintiffs' Standing Is Firmly Rooted in Basic Laws of Economics.

In *United Transportation Union v. Interstate Commerce Commission*, 891 F.2d 908, 912 n.7 (D.C. Cir. 1989), this Court stated that "allegations of future injury that are firmly rooted in the basic laws of economics" are sufficient. Thus, they are distinguishable from other allegations of future harm based on pure speculation. *See id*.

In *International Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 810 (D.C. Cir. 1983), this Court found standing for a union challenging the Labor Department's decision to repeal regulations that prevented employers from paying homeworkers sub-minimum wages. In rejecting the claim that it was unduly speculative whether this alleged injury would be redressed by the re-imposition of regulations on homeworkers' wages, the Court described the alleged injury and asserted that "we must accept these allegations as true for purposes of determining standing." *Id.* at 810 (citing *Warth*, 422 U.S. at 502). The allegation that the Court accepted as true in that case—that paying sub-minimum wages to

homeworkers will injure factory employees—was plausible because it was based upon the application of basic economic logic.

The same is true in this case. Because insurance premiums are based upon risk pools, and the Affordable Care Act's mandate to purchase and maintain ACA-compliant insurance was intended to drive people—particularly healthy people—into the risk pool in order to expand the pool and thus lower insurance premiums, any regulation that has the effect of reducing this risk pool will necessarily have an adverse effect on premiums. And this is particularly true when the effect is to reduce the risk pool such that those with the highest risk of incurring health care costs will remain in the pool.[3] That is basic economic logic. *See, e.g.*, *Clinton v. City of New York*, 524 U.S. 417, 433 (1998) (The Supreme Court "routinely recognizes probable economic injury resulting from [governmental actions] that alter competitive conditions as sufficient to satisfy the [Article III 'injury-in-fact' requirement]," and any party "who is likely to suffer economic injury as a result of [governmental action] that changes market conditions satisfies this part of the standing test." (citing 3 K. Davis & R. Pierce, Administrative Law Treatise 13-14 (3d ed. 1994))).

[3] One of the main purposes of the Affordable Care Act is to ensure that those persons with pre-existing health conditions are able to purchase health insurance. The mandate to purchase ACA-compliant plans was intended to reduce the cost of this adverse selection by driving healthy individuals into the market for such plans. 42 U.S.C. § 18091(2)(I) & (J). The challenged executive action undermines this very purpose of the Act.

Congress understood this basic logic and codified it as part of the factual findings to support the Act. *See* 42 U.S.C. § 18091(2)(I) & (J). These findings are relevant to the standing inquiry. *See, e.g., Int'l Ladies Garment Workers Union*, 722 F.2d at 807-08 ("The language and history unmistakably evidence an intent to protect all covered employees and employers from the economic consequences of subminimum wages paid to a small sector of the labor force.").

Plaintiffs' standing in this case is further affirmed by this Court's decision in *Sherley v. Sebelius*, 610 F.3d 69 (D.C. Cir. 2010). In *Sherley*, this Court found that a regulatory action that enlarges the pool of competitors seeking federal funding for grant proposals will "almost certainly cause an injury in fact" to those competitors within the same market. *Id*. at 73. Consequently, a regulatory action that shrinks the risk pool of insured, particularly an action that does so in a way that incentivizes those with higher health care costs (*i.e.*, those with pre-existing conditions) to remain in the pool since the available plans cannot exclude them as a matter of law while at the same time incentivizing those who are healthier to leave the pool and keep their non-compliant plan or seek an unlawful exemption, will "almost certainly cause an injury in fact" to those who remain in the pool. This is precisely what the challenged executive action is doing. *Cf. Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 45 n.25 (1976) ("The complaint in *Data Processing* alleged injury that was directly traceable to the action of the defendant

federal official, for it complained of injurious competition that would have been *illegal* without that action.") (emphasis added). Indeed, the non-compliant plans would be *illegal* without the executive action challenged here.

Supreme Court precedent also supports Plaintiffs' standing argument. In *General Motors Corporation v. Tracy*, 519 U.S. 278 (1997), the Court found that GMC had standing to challenge a tax imposed on the purchase of out-of-state natural gas because GMC would now "*presumably* pay[] more for the gas it gets from out-of-state producers and marketers." *Id*. at 286 (emphasis added).

No doubt, there are *many* factors that contribute to the price of natural gas. Variations in the amount of natural gas produced, the volume of natural gas being imported and/or exported, the amount of gas in storage facilities, the level of economic growth, variations in winter and summer weather, and the prices of competing fuels, among others, can have a dramatic impact on the price of natural gas. Consequently, even with the tax at issue, the *actual* price of natural gas from the day GMC filed suit to the date the Supreme Court held that GMC had standing to challenge the tax could have dropped significantly. Nevertheless, all things being equal (*ceteris paribus*), the tax was an *adverse* factor in the overall pricing of natural gas. Therefore, GMC had standing. The same is true here. Shrinking the risk pool by unlawful executive action, *ceteris paribus*, adversely affects the price of health insurance, causing injury to Plaintiffs.

In sum, Plaintiffs' basis for standing is firmly rooted in the basic laws of economics.

III. Because Plaintiff Muise Is Subject to Penalty for Non-Compliance with the Act, He Has Standing to Pursue His Claims.

In addition to establishing standing based upon the laws of economics, Plaintiff Muise independently has standing in light of the fact that he is subject to penalty if he does not purchase and maintain ACA-compliant health insurance.

This is no different than the situation presented in *Cutler v. U.S. Department of Health & Human Services*, 797 F.3d 1173 (D.C. Cir. 2015), in which the Court reversed the district court and found that Cutler had standing to pursue his Establishment Clause claim, stating: "Cutler is explicit that he is injured by being forced to choose between paying for compliant insurance and paying a penalty. That is the type of direct and concrete injury that satisfies Article III." *Id*. at 1180.

Plaintiff Muise must either purchase and maintain an ACA-compliant health care plan or pay a penalty, while others are permitted to purchase and maintain an *unlawful* health care plan and avoid any penalty.

As stated by the Court in *Lujan*, "[I]n order to establish standing depends considerably upon whether the plaintiff is himself an object of the action (or forgone action) at issue. If he is, there is ordinarily little question that the action or inaction has caused him injury, and that a judgment *preventing or requiring* the action will redress it." *Lujan*, 504 U.S. at 561-62 (emphasis added).

In sum, Plaintiffs are the object of *government* action and thus have standing. And it is incorrect to claim that the injury is not fairly traceable to the challenged executive actions, but to the independent actions of a third party (*i.e.*, BCBSM). The insurance company doesn't make the rules, nor does it enforce any penalties. The actions it takes—actions which harm Plaintiffs—are the direct result of the actions of the federal government. The penalty for not purchasing and maintaining an ACA-compliant plan comes from the federal government, not Plaintiffs' insurance provider. 26 U.S.C. § 5000A(a). And the ultimate authority to regulate the insurance provider and Plaintiffs' healthcare plan is the federal government, not the insurance provider itself. 42 U.S.C. § 300gg-22(a)(2) (stating that "the Secretary *shall enforce*" the Affordable Care Act's market reforms).

CONCLUSION

Plaintiffs request that the Court rehear this case en banc.

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CERTIFICATE OF COMPLIANCE

I certify that pursuant to Fed. R. App. P. 35, the foregoing petition is proportionally spaced, has a typeface of 14 points Times New Roman, and does not exceed 15 pages.

AMERICAN FREEDOM LAW CENTER

/s/ *Robert J. Muise*
Robert J. Muise, Esq.

Counsel Appellants

CERTIFICATE OF SERVICE

I hereby certify that on June 3, 2016, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system. I further certify that all of the participants in this case are registered CM/ECF users.

AMERICAN FREEDOM LAW CENTER

/s/ *Robert J. Muise*
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Counsel for Appellants

ADDENDUM

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued April 5, 2016 Decided May 13, 2016

No. 15-5164

AMERICAN FREEDOM LAW CENTER AND ROBERT JOSEPH MUISE,
APPELLANTS

v.

BARACK HUSSEIN OBAMA, IN HIS OFFICIAL CAPACITY AS PRESIDENT OF THE UNITED STATES OF AMERICA, ET AL.,
APPELLEES

Appeal from the United States District Court
for the District of Columbia
(No. 1:14-cv-01143)

Robert Joseph Muise argued the cause for appellants. With him on the briefs was *David Yerushalmi*.

Katherine Twomey Allen, Attorney, U.S. Department of Justice, argued the cause for appellees. With her on the brief were *Benjamin C. Mizer*, Principal Deputy Assistant Attorney General, and *Mark B. Stern* and *Alisa B. Klein*, Attorneys.

Before: GRIFFITH, SRINIVASAN and WILKINS, *Circuit Judges*.

Opinion for the Court filed by *Circuit Judge* WILKINS.

WILKINS, *Circuit* Judge: Appellants Robert Muise and American Freedom Law Center allege that their health insurance premiums increased by 57% at the end of 2014, and claim that the Affordable Care Act ("ACA") is to blame. Specifically, Appellants contend that in late 2013, the Department of Health and Human Services ("HHS") unlawfully implemented two policies: a "Transitional Policy," which permitted health insurance companies to temporarily continue providing health insurance plans that do not comply with ACA requirements; and a "Hardship Exemption," which permitted some individuals whose policies were cancelled for noncompliance to avoid the penalty under the individual mandate. These actions, Appellants argue, caused fewer people to purchase ACA-compliant plans. They assert that the Transitional Policy drove up the cost of ACA-compliant plans, such as the one purchased by Appellants. They also claim that HHS violated equal protection principles by applying either the Transitional Policy or the Hardship Exemption in a discriminatory fashion. At issue in this case is whether Appellants have standing to raise their challenges.

We affirm the District Court's determination that Appellants lack standing. Appellants have failed to demonstrate that the Transitional Policy caused Appellants' insurer, Blue Cross Blue Shield of Michigan ("Blue Cross"), to increase the premium for their health care plan specifically. Additionally, any alleged injury to Appellants from the Transitional Policy stemmed not from the Policy itself, which HHS applied evenhandedly, but from Blue Cross's decision not to take advantage of the Policy. Accordingly, Appellants also lack standing to bring their equal protection challenge.

I.

A.

The ACA, enacted by Congress in 2010, "aims 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). Among other things, the ACA institutes an individual mandate, which requires each "applicable individual" to purchase health insurance by maintaining "minimum essential coverage," and requires those who fail to do so to pay a "penalty." 26 U.S.C. § 5000A(a)-(c). In enacting the ACA, Congress acknowledged that the individual mandate was an important part of the overall functioning of the law, noting that "significantly increasing health insurance coverage . . . will minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." 42 U.S.C. § 18091(2)(I).

The ACA also imposes a number of new "market reforms," setting forth minimum standards that all offered health insurance plans must meet. *See, e.g.*, *id.* § 300gg (prohibiting discriminatory premium rates); *id.* § 300gg-1 (guaranteeing issuance of coverage); *id.* § 300gg-3 (prohibiting preexisting conditions exclusions); *id.* § 18022 (defining essential health benefits requirements). These reforms were scheduled to take effect on January 1, 2014. *See Cutler v. HHS*, 797 F.3d 1173, 1177 (D.C. Cir. 2015) (citing 42 U.S.C. § 300gg (note)). Prior to that time, certain health insurance providers began cancelling some health insurance plans that did not comply with the ACA's reforms. In a letter HHS sent to state insurance commissioners in November 2013, it explained that

> [a]lthough affected individuals and small businesses may access quality health insurance coverage through the new Health Insurance Marketplaces, in many cases with federal subsidies, some of them are finding that such coverage would be more expensive than their current coverage, and thus may be dissuaded from immediately transitioning to such coverage.

J.A. 43. To ameliorate this problem, HHS announced in its letter a Transitional Policy, whereby HHS would not enforce the ACA's market reform requirements against health insurance providers until October 2014. J.A. 43-45. It later extended that deadline ultimately to October 2017.[1] The Transitional Policy thus allowed individuals whose plans otherwise would have been terminated to keep their original health insurance during this transitional period, so long as their health insurance provider agreed to continue issuing their plan. The Policy, however, applies solely to health insurance providers, which are given the option of temporarily providing non-ACA-compliant plans, though they are not required to do so. The Policy does not apply to individuals, who still are required to comply with the ACA's individual mandate, unless they qualify for the Hardship Exemption.

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[1] In March 2014, HHS extended the policy for an additional two years, to October 1, 2016. J.A. 50-51. In February 2016, it extended the transitional period for an additional year, to October 1, 2017. Letter from Kevin Counihan, Dir., Ctr. for Consumer Info. & Ins. Oversight (February 29, 2016), www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf.

B.

Robert Muise is the co-founder and senior counsel of AFLC, a nonprofit corporation whose "mission . . . is to fight for faith and freedom through litigation, education, and public policy programs." Muise Decl. ¶¶ 2-4 (internal quotation marks omitted). Muise receives health insurance through AFLC's group health plan, which is issued by Blue Cross. *Id.* ¶ 6. After passage of the ACA, Blue Cross informed AFLC that its "current plan [was] changing" and that it would "be transitioning [AFLC] into a reform-compliant plan." J.A. 60. Thus, Blue Cross chose not to continue offering Appellants' original health insurance plan, even though it could have continued to do so during the period established by the Transitional Policy. Appellants allege that when Blue Cross transitioned to that reform-compliant plan, the monthly premium AFLC paid for Muise's health insurance plan increased from $1,349.96 to $2,121.59 – an increase of 57% ($771.63). *See* Muise Decl. ¶ 13.

In a June 2014 rate filing, Blue Cross explained that there would be a 2.7% rate increase for 2015 "for all small group products that were offered in 2014," such as Appellants' plan. J.A. 80. They listed four "[s]ignificant drivers of the rate change," one of which was "[l]ower than anticipated improvement of the ACA compliant market level risk pool in 2014 and 2015 due to the market being allowed to extend pre-ACA . . . plans into 2016." *Id.* In other words, Blue Cross blamed the rate increase, in part, on the ability of individuals to retain non-ACA-compliant coverage, presumably due to HHS's Transitional Policy. In a later, March 2015 rate filing,[2] Blue Cross reversed course, and noted that there

[2] This filing was not included in the record before the District Court or before us on appeal, but it is publicly available. *See* Actuarial Memorandum, Blue Cross Blue Shield Michigan, BCBSM 2015

would be a 3.3% decrease for policies issued between July 1, 2015, and December 31, 2015. 2015 Blue Cross Filing 6. It listed two "[s]ignificant drivers" for the rate change: (1) "2014 trend results coming in much lower than anticipated"; and (2) "[s]hifts in market risk assumptions after the allowance by the government for carriers to extend offerings of pre-reform plans." *Id.* Thus, although Blue Cross appeared to blame its initial rate increase, in part, on the consequences of the Transitional Policy, it seemed to also credit, in part, the Policy with the later rate decrease.

Appellants filed suit in July 2014, challenging the Transitional Policy as an "unlawful executive action[]" issued by "executive fiat." Compl. ¶¶ 33, 46. They claim that the Policy caused their health insurance costs to increase. *Id.* ¶ 49. Additionally, they assert an equal protection challenge, claiming that Appellees violated the Fifth Amendment by allowing certain individuals to benefit from the Policy, thereby exempting them from the individual mandate, but not providing this exemption to others, including Appellants. *Id.* ¶ 62.

The District Court granted Appellees' motion to dismiss the case pursuant to Rule 12(b)(1) of the Federal Rules of Civil procedure, holding that Appellants lacked standing. *Am. Freedom Law Ctr. v. Obama*, 106 F. Supp. 3d 104, 113 (D.D.C. 2015). It determined, among other things, that Appellants had failed to demonstrate that whatever injury they

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Small Group Rate Filing (Mar. 23, 2015), https://filingaccess.serff.com/sfa/home/MI (follow "Begin Search"; follow "Accept"; enter "BBMI-129573445" in the field labeled "SERFF Tracking Number"; select "Blue Cross Blue Shield of Michigan"; select the document titled "Actuarial Memorandum 3Q2015 BCBSMSG 20150330 Final.pdf") [hereinafter 2015 Blue Cross Filing].

alleged to have suffered was caused by HHS's Transitional Policy, noting that "health insurance premiums fluctuate for myriad reasons, ranging from the particular terms of coverage to various other actuarial factors." *Id.* at 109.

II.

The only question in this appeal is whether Appellants have standing to bring this suit. Because they have failed to show that the increase in their health care premiums stems from HHS's Transitional Policy, Appellants have not demonstrated that they have standing. We affirm the District Court's dismissal pursuant to Rule 12(b)(1).

A.

We review a District Court's decision regarding standing *de novo*. *Info. Handling Servs., Inc. v. Def. Automated Printing Servs.*, 338 F.3d 1024, 1029 (D.C. Cir. 2003). The "irreducible constitutional minimum of standing contains three elements": (1) injury-in-fact, (2) causation, and (3) redressability." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992). Stated differently, "a litigant must demonstrate a 'personal injury fairly traceable to the [opposing party's] allegedly unlawful conduct and likely to be redressed by the requested relief.'" *Ass'n of Flight Attendants-CWA, AFL-CIO v. U.S. Dep't of Transp.*, 564 F.3d 462, 464 (D.C. Cir. 2009) (quoting *Allen v. Wright*, 468 U.S. 737, 751 (1984)).

When "[t]he existence of one or more of the essential elements of standing 'depends on the unfettered choices made by independent actors not before the courts and whose exercise of broad and legitimate discretion the courts cannot presume either to control or to predict,'" it becomes "'substantially more difficult' to establish" standing. *Lujan*, 504 U.S. at 562 (quoting *ASARCO Inc. v. Kadish*, 490 U.S.

605, 615 (1989) (opinion of Kennedy, J.); *Allen*, 468 U.S. at 758); *accord Nat'l Wrestling Coaches Ass'n v. Dep't of Educ.*, 366 F.3d 930, 938 (D.C. Cir. 2004). "[M]ere 'unadorned speculation' as to the existence of a relationship between the challenged government action and the third-party conduct 'will not suffice to invoke the federal judicial power.'" *Nat'l Wrestling*, 366 F.3d at 938 (quoting *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 44 (1976)). "The greater number of uncertain links in a causal chain, the less likely it is that the entire chain will hold true." *Fla. Audubon Soc'y v. Bentsen*, 94 F.3d 658, 670 (D.C. Cir. 1996) (en banc). However, where "the alleged injury flows not directly from the challenged agency action, but rather from independent actions of third parties, we have required only a showing that 'the agency action is at least a substantial factor motivating the third parties' actions.'" *Tozzi v. HHS*, 271 F.3d 301, 308 (D.C. Cir. 2001) (quoting *Cmty. for Creative Non-Violence v. Pierce*, 814 F.2d 663, 669 (D.C. Cir. 1987)).

In considering a motion to dismiss for lack of subject matter jurisdiction, courts are required to "accept as true all of the factual allegations contained in the complaint." *Swierkiewicz v. Sorema N.A.*, 534 U.S. 506, 508 n.1 (2002). Nonetheless, we "may consider materials outside the pleadings in deciding whether to grant a motion to dismiss for lack of jurisdiction." *Jerome Stevens Pharm., Inc. v. FDA*, 402 F.3d 1249, 1253 (D.C. Cir. 2005).

B.

Accepting, for the sake of argument, that Appellants have demonstrated that they have suffered a concrete injury in fact, they have failed to show that HHS's Transitional Policy caused that injury. At oral argument, Appellants conceded that the injury they claim is solely a prospective one; they

assert that the Transitional Policy will cause them to pay more for their health insurance in the future. This assumption, however, is speculative.

The only evidence Appellants offer to demonstrate that the Policy caused, or will cause, their alleged injury is Blue Cross's 2014 rate increase filing, which included as a reason for the rate increase the fact that the overall risk pool for ACA-compliant plans was smaller than Blue Cross had anticipated. But that statement alone is not enough to show causation here.

First, it is unclear whether the rate increase discussed in Blue Cross's filing applied to Appellants' health care plan at all. The filing stated that Blue Cross's rates would increase overall by 2.7%, but makes clear that the increase was an average across all of Blue Cross's plans. It notes that the rate changes discussed in the filing "vary slightly by product and plan," J.A. 80, and provides a chart showing that some plans increased by as much as 3.3%, while others did not increase at all. *See id.* at 81. Appellants failed to specify before the District Court which plan Blue Cross transitioned them to after it discontinued their old plan, *see Am. Freedom Law Ctr.*, 106 F. Supp. 3d at 112, and they have provided no further information on appeal. We are therefore left to guess whether Appellants' current plan was one of the plans for which Blue Cross noted a rate increase in its 2014 filing.

Second, although it appears that the price of at least some of Blue Cross's plans increased at the beginning of 2015, the price of those same plans appears to have decreased in the second half of 2015.[3] According to Appellants, "basic

[3] Unlike its June 2014 filing, which showed a price increase in only certain plans, Blue Cross's March 2015 filing showed a decrease in every plan's price. *See* 2015 Blue Cross Filing 7.

economic principles" establish a direct link between the supposed decrease in the number of individuals in ACA-compliant risk pools allegedly caused by HHS's Transitional Policy and the asserted increase in the price of Appellants' health insurance plan. Appellant's Br. 41. But as Blue Cross's two rate filings reveal, the effect of various factors, including the size of risk pools, on health insurance pricing is far from "basic," and Appellants have made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future, let alone that such an increase will stem from the Transitional Policy. This is a major missing link in the causal chain Appellants must establish to demonstrate that HHS's Transitional Policy is a "substantial factor motivating" Appellants' alleged harm. *Tozzi*, 271 F.3d at 308 (quoting *Cmty. for Creative Non-Violence*, 814 F.2d at 669).

Moreover, as discussed above, we do not know whether Appellants' health insurance plan was one of the plans affected by the rate increase discussed in Blue Cross's 2014 filing. Accordingly, even if we did accept that HHS's Transitional Policy was a "substantial factor motivating" the rate increase Blue Cross discusses in that rate filing, Appellants have not linked that rate increase to their own alleged injury.

To circumvent the holes in their causation theory, Appellants rely principally on our decision in *Center for Auto Safety v. NHTSA*, 793 F.2d 1322 (D.C. Cir. 1986). That case involved the Corporate Average Fuel Economy ("CAFE") standards set by the National Highway Traffic Safety Administration ("NHTSA"), which determine how fuel efficient an overall fleet of vehicles must be. The Center for Auto Safety challenged NHTSA's 1985 CAFE standard, which allowed light trucks to be 1.5 miles per gallon less fuel

efficient than its previous standard. *See id.* at 1323. Assessing whether the Center had standing to bring its suit, we considered whether its alleged injury – its members' inability to buy more fuel-efficient trucks, *see id.* at 1324 – was caused by NHTSA's new CAFE standard. We found "no difficulty in linking the petitioners' injury to the challenged agency action," *id.* at 1334, stating that "the agency's regulation and the injury are . . . directly linked" because "NHTSA sets standards for the purpose of making vehicles more fuel-efficient," and "petitioners, in turn, complain of less fuel-efficient vehicles." *Id.* We explained that "[i]f setting a higher standard cannot result in vehicles with increased fuel efficiency, then the entire regulatory scheme is pointless." *Id.* at 1334-35. We also noted that the case "involves none of the multiple, tenuous links between challenged conduct and asserted injury that have characterized claims in which causation has been found lacking." *Id.* at 1335.

Based on their reading of *Center for Auto Safety*, Appellants argue that "increasing health insurance coverage and the size of purchasing pools" is "pointless" if it does not bring down health care costs. Appellants' Br. 36 (emphasis omitted). Accordingly, they contend that there must be a direct link between HHS's Transitional Policy, which allegedly decreased the size of those purchasing pools, and the increase in Appellants' premiums. The instant case, however, is easily distinguished from *Center for Auto Safety*. There, NHTSA set a specific floor auto manufacturers were required to follow. Thus, if NHTSA determined that a truck fleet had to meet, on average, a 20-miles-per-gallon fuel efficiency rating, the average fuel efficiency of a manufacturer's truck fleet could not fall below 20 miles per gallon. There were also no outside factors that could interact with fuel efficiency standards to alter that floor.

The instant case is different. First, although one of Congress's goals in drafting the ACA was to decrease the cost of health care, *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2580, the ACA establishes no floor under which health care prices cannot drop, nor a ceiling above which prices cannot rise. Second, many factors determine the cost of health care, including administrative costs, drug costs, and the health and age of the national populace. *See generally* BIPARTISAN POLICY CTR., WHAT IS DRIVING U.S. HEALTH CARE SPENDING? AMERICA'S UNSUSTAINABLE HEALTH CARE COST GROWTH (September 2012), http://bipartisanpolicy.org/library/what-driving-us-health-care-spending-americas-unsustainable-health-care-cost-growth/ (providing a "basic overview of the drivers of health care cost growth," and noting that such drivers are "complex and overlapping"). Changes in any of these factors could cause costs to increase or decrease, and it is difficult to separate out which factors actually cause any specific price adjustment. Unlike *Center for Auto Safety*, where the Center established a direct link between NHTSA's CAFE standards and the fuel efficiency of vehicles, Appellants have made no attempt to separate out any of these factors. As a result, they have not established a sufficient link between the size of the risk pools at issue here and the cost of their health care.

Accordingly, Appellants have failed to demonstrate that HHS's Transitional Policy caused the alleged increase in their health insurance policy's price; they lack standing to challenge the Transitional Policy on that ground.

C.

"The 'injury in fact' element of standing in . . . an equal protection case is the denial of equal treatment resulting from the imposition of the barrier . . . ." *Ne. Fla. Chapter of*

Associated Gen. Contractors of Am. v. City of Jacksonville, Fla., 508 U.S. 656, 666 (1993). Appellants' second standing argument is that HHS discriminated against Muise when it "unlawfully exempted some 'applicable individuals' (and their plans) . . . from the Individual Mandate," but not him. Appellants' Br. 42-43. Although Appellants evidently intend to contend that HHS has denied Muise equal treatment with respect to the Hardship Exemption, Muise cannot demonstrate injury in that regard: Muise is insured and thus is not subject to the penalty in the first place (such that the exemption would be of no benefit to him).

Appellants also evidently raise an equal protection challenge with regard to the Transitional Policy. They contend that because only some individuals were able to benefit from the Transitional Policy (namely, those individuals whose plan is issued by a health insurance company that took advantage of the Policy), HHS applied its policy discriminatorily. Our precedent directly refutes this claim.

In *Cutler v. HHS*, a plaintiff whose health insurance plan was cancelled by his health insurance company because the plan was not ACA-compliant brought suit challenging HHS's Transitional Policy. 797 F.3d at 1175. Among other things, plaintiff challenged the Policy as depriving him of equal protection of the law. *Id.* at 1183. We held that he lacked standing to bring his challenge:

> Cutler lacks Article III standing to pursue his equal protection challenge because his alleged injury is not fairly traceable to the transitional policy, nor would it be redressed by striking down that policy. The transitional policy applies evenhandedly across the United States,

> so if Cutler cannot obtain the insurance he desires and others can, that is because his own insurer cancelled his policy. Cutler's injury is thus the result of the action of his private insurer, not the transitional policy, and it is purely speculative whether an order in this case would alter or affect the non-party insurers' decision.

Id. at 1183-84.

Cutler is directly on point here. Appellants' inability to benefit from the Transitional Policy stems not from the actions of HHS, which applied the Policy "evenhandedly," but from Blue Cross's decision to discontinue Appellants' policy. Thus, for the same reasons established in *Cutler*, Appellants' "alleged injury is not fairly traceable to the transitional policy, nor would it be redressed by striking down that policy." *Id.* at 1183.

Appellants therefore lack standing to challenge the Transitional Policy on equal protection grounds.

***

For the foregoing reasons, we affirm the District Court's judgment.

So ordered.

CERTIFICATE AS TO PARTIES

Plaintiffs-Appellants American Freedom Law Center and Robert Joseph Muise hereby submit the following pursuant to Circuit Rules 28(a)(1)(A) and 35(c):

The following list includes all parties, intervenors, and amici who have appeared before the district court, and all persons who are parties, intervenors, or amici in this Court.

Plaintiffs-Appellants:

American Freedom Law Center

Robert Joseph Muise

Defendants-Appellees:

Barack Obama, President of the United States of America

United States Department of Health and Human Services

Sylvia Mathews Burwell, Secretary, United States Department of Health and Human Services

United States Department of the Treasury

Jacob J. Lew, Secretary, United States Department of the Treasury

United States Department of Labor

Thomas E. Perez, Secretary, United States Department of Labor

Respectfully submitted,

AMERICAN FREEDOM LAW CENTER

/s/ *Robert J. Muise*
Robert J. Muise, Esq.

/s/ *David Yerushalmi*
David Yerushalmi, Esq. (D.C. Bar No. 978179)

Counsel for Appellants

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and D.C. Cir. Rule 26.1, Plaintiff-Appellant American Freedom Law Center, through undersigned counsel, states as follows: the American Freedom Law Center is a nonprofit corporation managed by its board of directors, all of whom are individuals. The American Freedom Law Center has no parent, subsidiary, or affiliated corporation, and no public entity has any ownership interest in the American Freedom Law Center.

Respectfully submitted,

AMERICAN FREEDOM LAW CENTER

/s/ *Robert J. Muise*
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