[ORAL ARGUMENT NOT YET SCHEDULED]

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JEFFREY CUTLER, Plaintiff-Appellant, -v- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants-Appellees.	Appeal No. 14-5183

PLAINTIFF-APPELLANT'S MOTION FOR INJUNCTION PENDING APPEAL, OR IN THE ALTERNATIVE, TO EXPEDITE

AMERICAN FREEDOM LAW CENTER

Robert J. Muise, Esq.
P.O. Box 131098
Ann Arbor, Michigan 48113
Tel: (734) 635-3756

David Yerushalmi, Esq.
1901 Pennsylvania Avenue NW, Suite 201
Washington, D.C. 20006
Tel: (646) 262-0500

Counsel for Plaintiff-Appellant

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INTRODUCTION

Pursuant to Rule 8 of the Federal Rules of Appellate Procedure and D.C. Circuit Rule 8, Plaintiff-Appellant Jeffrey Cutler ("Plaintiff"), hereby moves this court for the entry of an order granting an injunction pending appeal that enjoins the enforcement of the individual mandate of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("Affordable Care Act" or "Act"), including its penalty provision and associated regulations, as applied to Plaintiff and his prospective healthcare plan and insurer while this case proceeds.[1] Plaintiff is currently subject to penalty because he is not covered by insurance—insurance that was cancelled because of the Act.[2]

An injunction pending appeal will preserve the *status quo*, protect Plaintiffs' constitutional rights, and not harm the interests of Defendants or the public while this court resolves the significant legal issues presented by this important case involving the Act and its impact on the constitutional rights of a private citizen.[3]

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[1] Because the challenged mandate also imposes obligations upon any insurer Plaintiff would contract with, Plaintiff requests that the court enter an order that would enjoin Defendants from taking any enforcement action against Plaintiff, any future group health plan he might purchase, or the group health insurance coverage provided in connection with such plan, for not providing the coverage required by the Act.

[2] Alternatively, Plaintiff requests that the court expedite this appeal because he is currently subject to penalty and unable to keep his health insurance.

[3] The district court dismissed Plaintiff's Complaint on standing grounds and for failure to state a claim. (A copy of the district court's Order and a copy of the court's Memorandum Opinion are attached to this motion as Exhibit 1).

PROCEDURAL POSTURE OF THE CASE

Plaintiff, who was acting *pro se*, filed his Complaint on December 31, 2013. (Compl. [Doc. No. 1]). Plaintiff has no formal legal education or training, (Cutler Decl. ¶¶ 6, 19 at Ex. 2), and he continued to represent himself through the initial phases of this appeal.[4]

As set forth in the district court's Memorandum Opinion (Doc. No. 21 ["Mem. Op."]),[5] Plaintiff has advanced several claims challenging the Affordable Care Act, including claims arising under the First (Establishment Clause) and Fifth (equal protection) Amendments. (Mem. Op. at 3).

As this court recently affirmed, it must "afford a liberal reading to a complaint filed by a *pro se* plaintiff," particularly when the plaintiff has no formal legal training or education. *Klayman v. Zuckerberg*, 753 F.3d 1354, 1357 (D.C.

Consequently, requesting an injunction pending appeal first in the district court would have been "impracticable." *See* Fed. R. App. P. 8(a)(2)(A)(i)(ii); D.C. Cir. R. 8(a)(1). Plaintiff's counsel notified opposing counsel that Plaintiff would be filing this motion. Defendants oppose the motion. All parties have filed their respective notices of appearance. Therefore, Defendants will be served with this motion electronically. *See* Fed. R. App. P. 8(a)(2)(C); D.C. Cir. R. 8(a)(2).

[4] On September 6, 2014, counsel entered their appearances in this court on behalf of Plaintiff. Upon reviewing the file and concluding that an injunction pending appeal was necessary due in large measure to the fact that Plaintiff is currently incurring a "penalty" under the Act for not having insurance, on September 16, 2014, Plaintiff, through counsel, filed an unopposed motion to extend the time in which motions were due. That motion was granted, and this motion now follows.

[5] The court granted Defendants' motion to dismiss (Doc. No. 9), denied Plaintiff's motion for partial summary judgment (Doc. No. 12), and denied Plaintiff's renewed motion for summary judgment (Doc. No. 18). (Mem. Op. at 18-19).

Cir. 2014); *see also Erickson v. Pardus*, 551 U.S. 89, 94 (2007) ("A document filed *pro se* is to be liberally construed, and a *pro se* complaint, however inartfully pleaded, must be held to less stringent standards than formal pleadings drafted by lawyers.") (internal quotations and citations omitted). Indeed, Plaintiff prays that the court carefully considers for purposes of this motion (and the accompanying appeal) the fact that the underlying causes of action were advanced while Plaintiff was *pro se*, and hereby requests that the court liberally construe the claims presented "so as to do justice." *See* Fed. R. Civ. P. 8(e) ("Pleadings must be construed so as to do justice.").[6]

LEGAL STANDARD

When deciding whether to grant the requested injunction, this court will consider the following factors: "(i) the likelihood that the moving party will prevail on the merits; (ii) the prospect of irreparable injury to the moving party if relief is withheld; (iii) the possibility of harm to other parties if relief is granted; and (iv) the public interest." D. C. Cir. R. 8(a); *see also Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (same). And as this court stated in *Wash. Metro. Area Transit Comm'n. v. Holiday Tours, Inc.*, 559 F.2d 841, 844 (D.C. Cir. 1977):

[6] An alternative relief that Plaintiff will be seeking through this appeal is a request that the case be remanded to permit him to amend his pleadings now that he has the benefit of counsel. *See* Fed. R. Civ. P. 15(a)(2) (stating that a "court should freely give leave [to amend] when justice so requires").

> An order maintaining the *status quo* is appropriate when a serious legal question is presented, when little if any harm will befall other interested persons or the public and when denial of the order would inflict irreparable injury on the movant. There is substantial equity, and need for judicial protection, whether or not movant has shown a mathematical probability of success.

Thus, as set forth further below, an order granting the requested injunction and thereby maintaining the *status quo* while this appeal is pending is warranted.

STATEMENT OF FACTS

A. The Affordable Care Act and the Individual Mandate.

In 2010, Congress enacted the 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). 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. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012). By enacting the Affordable Care Act, Congress nationalized healthcare insurance by placing its requirements within federal control.

To accomplish its purpose, the Act requires, *inter alia*, each "applicable individual" to purchase and maintain "minimum essential" health insurance coverage ("individual mandate"). Individuals who fail to do so must pay a "penalty." *See* 26 U.S.C. § 5000A(b)(1). The mandate was required 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 . . . is covered under minimum essential coverage for such month.").

As support for this mandate, 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. 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 individual mandate "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). *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2668-76 (Scalia, J., Kennedy, J., Thomas, J., Alito, J., dissenting) (concluding that the individual mandate is not severable). Consequently, through the universal (and federal) enforcement of the mandate, Congress sought to ensure that those who are required to purchase a compliant policy (an "adverse selection") would at least benefit from "lower health insurance premiums" and not be further burdened by the inevitably

higher costs associated with purchasing and maintaining the "minimum essential coverage" required by the Act. *See* 42 U.S.C. § 18091(2)(I) & (J).

Yet, despite this federal need for universal enforcement of the mandate, Congress provided certain exemptions, "including one for persons certified as members of an exempt religion or sect, and for members of a health care sharing ministry."[7] (Mem. Op. at 2 [citing 26 U.S.C. § 5000A(d)(2) (2010)]). Plaintiff does not qualify for any exemption under the Act. (Cutler Decl. ¶¶ 5, 26 at Ex. 2).

B. "If You Like Your Health Care Plan, You Can Keep It."

In 2013, President Obama promised the American people that "if you like your health care plan, you can keep it." Even today, the President is assuring the American people that "if you like the insurance you have, keep it," stating that "[n]othing in the proposal forces anyone to change the insurance they have. Period." *See* http://www.whitehouse.gov/health-care-meeting/proposal/titlei/keepit (last visited on Oct. 10, 2014). (Cutler Decl. ¶ 15 at Ex. 2).

To make good on his promise, the President engaged in a series of executive actions. In November 2013, President Obama announced a "transitional policy" that would allow Americans whose insurance companies cancelled their health care coverage to remain in their non-compliant plans. This "transitional policy"

[7] The Act also does not apply to so-called "grandfathered" health care plans. *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.

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 (hereinafter "CMS"). (Cutler Decl. ¶ 16, Ex. A, at Ex. 2).

In this letter, the Director acknowledged that "[s]ome individuals . . . with health insurance coverage have been notified by their health insurance issuers that their coverage will soon be terminated. . . . 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." 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 Act. (Cutler Decl. ¶ 16, Ex. A, at Ex. 2).

On December 19, 2013, CMS issued another directive, which 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 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*." (Cutler Decl. ¶ 17, Ex. B, at Ex. 2) (emphasis added).

On March 5, 2014, CMS confirmed the "transitional policy" previously announced by the President and further 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." (Cutler Decl. ¶¶ 20-22, Ex. C, at Ex. 2).

Although the Affordable Care Act applies to all citizens, the application of the "transitional policy" is dependent upon the State in which a citizen resides. (Cutler Decl. ¶¶ 3, 13-18, 20-25, Exs. A-C, at Ex. 2; *see also infra* sec. II).

C. Irreparable Harm to Plaintiff.

Plaintiff, a resident of Pennsylvania who is Jewish by birth, is an "applicable individual" and not eligible for any statutory exemption to the Affordable Care Act. Plaintiff suffers from diabetes and hypertension, and recently had to undergo heart bypass surgery to correct a life-threatening blockage in his artery junction known as the "widow maker artery." Since 2007, Plaintiff had a health insurance plan through Highmark Blue Shield—a plan which he liked because it provided the coverage he wanted and needed, it allowed him to see the doctors that he preferred, and it was affordable. In October 2013, Plaintiff received notice that his health insurance would be terminated on December 31, 2013, because of the Affordable Care Act. Plaintiff's insurance was in fact canceled. As a result, he was unable to complete his cardiac rehabilitation. Plaintiff has been without health insurance

since January 1, 2014. When he tried to purchase insurance from Highmark on September 15, 2014, he was unable to do so because of the Act. In fact, Plaintiff cannot even attempt to purchase health insurance again until November 15, 2014 (and this insurance will not become effective until January 1, 2015), because of the Affordable Care Act. (Cutler Decl. ¶¶ 1-26 at Ex. 2).

ARGUMENT

I. Plaintiff Has Standing to Assert His Claims.

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). 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.*

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." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (emphasis added).

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) (acknowledging that regulations injuring a plaintiff's "economic interests" create the necessary injury-in-fact). Moreover, and most important for purposes of this case, "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." *Nat'l Rifle Assoc. of Am. v. Magaw*, 132 F.3d 272, 282 (6th Cir. 1997); *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.

Here, Plaintiff is currently subject to the mandate and its penalty provision. In fact, the penalty is now accruing. *See* 26 U.S.C. § 5000A(a), (b) & (c). Moreover, Plaintiff's health insurance—a plan which he liked and wanted to keep—was cancelled as a result of the Act. Yet other citizens, depending upon the State in which they reside, are able to keep their non-compliant plans as well as

avoid a penalty. (*See infra* sec. II). Thus, the Act is being applied in a discriminatory manner. In sum, there is "little question" that Plaintiff has standing[8] because he has alleged a "personal injury" that is "fairly traceable" to the Act and is "likely to be redressed by the requested relief."[9] *See Allen*, 468 U.S. at 751.

II. The Mandate, as Applied, Violates Equal Protection.

The Supreme Court's "approach to Fifth Amendment equal protection claims has always been precisely the same as to equal protection claims under the Fourteenth Amendment." *Weinberger v. Wiesenfeld*, 420 U.S. 636, 638 n.2 (1975). Consequently, case law interpreting the Equal Protection Clause of the Fourteenth Amendment is applicable when reviewing an equal protection claim

[8] The district court's assertion that "Plaintiff in the instant action only establishes that he is subject to the individual mandate along with all other nonexempt individuals; he has claimed no actual injury that is personalized to him" (Mem. Op. at 12) is incorrect. Similarly, the legal conclusion the court draws from this assertion that the "complained injury is one that applies equally to every citizen, and thus is a generalized grievance insufficient to confer standing" (Mem. Op. at 12 [internal quotations and citation omitted]) is plainly erroneous. Indeed, the plaintiffs who challenged the individual mandate in 2010 had standing even though the mandate would not go into effect until 2014. *See, e.g., Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2566; *Seven-Sky v. Holder*, 661 F.3d 14 (D.C. Cir. 2011); *Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 539 (6th Cir. 2011).

[9] "[G]iven the evolution of the taxpayer standing doctrine, . . . and in an abundance of caution," the district court did "address Plaintiff's claim that the religious exemption to the individual mandate violates the Establishment Clause by giving preference to one religion over another and allowing the government to certify that members of certain religions are exempt from the individual mandate." (Mem. Op. at 16). And while Plaintiff agrees that he has standing to advance an Establishment Clause claim, he disagrees with the district court's conclusion. (*See infra* sec. III).

arising under the Fifth Amendment, as in this case.[10]

It is axiomatic that the constitutional guarantee of equal protection embodies the principle that all persons similarly situated should be treated alike. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) ("The guaranty of equal protection of the laws is a pledge of the protection of equal laws.") (internal quotations and citation omitted). And this constitutional guarantee applies to administrative as well as legislative acts. *Raymond v. Chicago Union Traction Co.*, 207 U.S. 20, 35-36 (1907).

Supreme Court equal protection jurisprudence has typically been concerned with governmental classifications that "affect some groups of citizens differently than others." *McGowan v. Maryland*, 366 U.S. 420, 425 (1961); *Ross v. Moffitt*, 417 U.S. 600, 609 (1974) ("'Equal Protection' . . . emphasizes disparity in treatment by a State between classes of individuals whose situations are arguably indistinguishable."). Indeed, the equal protection guarantee is violated when the government creates benefits and burdens based on residency such that "some citizens are more equal than others." *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). This is often expressed as

[10] This case involves an equal protection claim arising under the Fifth Amendment because the defendants are agents of the federal government. *See, e.g., Bolling v. Sharpe*, 347 U.S. 497, 499 (1954); (*see also* Mem. Op. at 4 n.3 [treating Plaintiff's equal protection claim "as a claim brought under the Fifth Amendment"]).

infringing upon the right to travel or as depriving a person of the privileges and immunities afforded all citizens,[11] but nonetheless a violation of equal protection. *See, e.g.*, *id.* at 67, 70 (Brennan, J., concurring) (observing that "the right to travel achieves its most forceful expression in the context of equal protection analysis" and stating that "equality of citizenship is of the essence in our Republic"); *see also Saenz v. Roe*, 526 U.S. 489, 499 (1999) ("We further held that a classification that had the effect of imposing a penalty on the exercise of the right to travel violated the Equal Protection Clause unless shown to be necessary to promote a *compelling* governmental interest . . . ."") (internal quotations and citation omitted); *Shapiro v. Thompson*, 394 U.S. 618, 643 (1969) (Stewart, J., concurring) (observing that the right to "travel" is "a virtually unconditional personal right, guaranteed by the Constitution to us all"). As stated by the Court:

> A citizen of the United States has a perfect constitutional right to go to and reside in any State he chooses, and to claim citizenship therein, and an equality of rights with every other citizen; and the whole power of the nation is pledged to sustain him in that right. He is not bound to cringe to any superior, or to pray for any act of grace, as a means of enjoying all the rights and privileges enjoyed by other citizens.

Saenz, 526 U.S. at 503-04 (internal quotations and citation omitted).

Indeed, the equal protection guarantee, like the Constitution itself, was "framed upon the theory that the peoples of the several states must sink or swim

[11] Article IV, section 2, provides: "The Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States."

together, and that in the long run prosperity and salvation are in union and not division." *Baldwin v. G. A. F. Seelig, Inc.*, 294 U.S. 511, 523 (1935) (Cardozo, J.). Consequently, the inequitable enforcement of the law based upon where one resides conflicts fundamentally with the constitutional purpose of maintaining a "Union" rather than a mere "league of States" and similarly runs afoul of our Constitution's pledge of equal protection. *See Paul v. Virginia*, 8 Wall. 168, 180 (1869). As stated more fully by the Court:

> It was undoubtedly the object of the [Privileges and Immunities] clause in question to place the citizens of each State upon the same footing with citizens of other States, so far as the advantages resulting from citizenship in those States are concerned. It relieves them from the disabilities of alienage in other States; it inhibits discriminating legislation against them by other States; it gives them the right of free ingress into other States, and egress from them; it insures to them in other States the same freedom possessed by the citizens of those States in the acquisition and enjoyment of property and in the pursuit of happiness; and it secures to them in other States the equal protection of their laws. It has been justly said that no provision in the Constitution has tended so strongly to constitute the citizens of the United States one people as this. Indeed, without some provision of the kind removing from the citizens of each State the disabilities of alienage in the other States, and giving them equality of privilege with citizens of those States, the Republic would have constituted little more than a league of States; it would not have constituted the Union which now exists.

Id. In sum, a regulatory scheme—in this case, a regulatory scheme imposed by the federal government—that results in disparate benefits and burdens based upon the State in which a person resides is a form of discrimination that violates the equal protection guarantee of the Constitution—a guarantee that itself resides in the Fifth

and Fourteenth Amendments. Here, the enforcement of the Act—and in particular, the mandate requiring "applicable individuals" to purchase and maintain insurance that is compliant *with federal law*—is not universally and thus not equally enforced throughout the nation but is principally dependent upon the State in which a citizen resides as to whether the individual can "keep his healthcare plan if he likes it." *See generally Holder v. City of Allentown*, 987 F.2d 188, 197 (3d Cir. 1993) ("[I]t has long been established that discriminatory enforcement of a statute or law by state and local officials is unconstitutional."). Indeed, Plaintiff liked his healthcare plan, but was unable to keep it because he resided in Pennsylvania—a State in which insurance companies were permitted to cancel non-compliant plans unlike in other States. And it is not correct to say that since Plaintiff has completed his interstate travel (*i.e.*, he wants to remain in Pennsylvania) that this "perfect constitutional right" of his as a citizen is only affected "incidentally." Indeed, since Plaintiff has the right to be treated equally, "the discriminatory classification is itself a penalty." *Saenz*, 526 U.S. at 505.

In sum, the federal government "has no affirmative power to authorize the States to violate the Fourteenth Amendment and is implicitly prohibited from passing legislation that purports to validate any such violation." *Id.* at 508. "[N]either Congress nor a State can validate a law that denies the rights guaranteed by the Fourteenth Amendment," *id.*—rights also secured by the Fifth Amendment.

III. The Mandate Violates the Establishment Clause.

"The First Amendment mandates governmental neutrality between religion and religion, and between religion and nonreligion." *Epperson v. Arkansas*, 393 U.S. 97, 104 (1968). Even "subtle departures from neutrality" are prohibited. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 534 (1993). Consequently, laws that discriminate on the basis of religion run afoul of the First Amendment. Indeed, "[t]he clearest command of the Establishment Clause is that one religious denomination cannot be officially preferred over another." *Larson v. Valente*, 456 U.S. 228, 244 (1982); *see also Commack Self-Service Kosher Meats, Inc. v. Weiss*, 294 F.3d 415, 423-27 (2d Cir. 2002) (holding that the State's defining of "kosher" as "prepared in accordance with orthodox Hebrew religious requirements" violated the First Amendment because it suggested a "preference for the views of one branch of Judaism"); *Everson v. Bd. of Educ.*, 330 U.S. 1, 15-16 (1947) ("The 'establishment of religion' clause . . . means at least this: Neither a state nor the Federal Government . . . can pass laws which aid one religion, aid all religions, or prefer one religion over another. . . .").

The district court concluded that the religious exemption does not make "'explicit and deliberate distinctions' between different religions or sects." (Mem.

Op. at 17-18). This conclusion is wrong.[12] Indeed, the exemption is not simply a religious accommodation that is applicable to all religions.[13] Rather, it plainly rewards certain religious beliefs (and thus sects) over others. Per the exemption, it applies only: (1) "to a member of a *recognized* religious sect or division"; (2) who is "an *adherent* of *established tenets or teachings* of such sect or division"; and (3) "by reason of [these established tenets or teachings,] is conscientiously opposed to acceptance of the benefits of any private or public insurance." *See* 26 U.S.C. § 5000A; 26 U.S.C. § 1402(g)(1). Plaintiff is "conscientiously" opposed to being forced to purchase government-mandated insurance, but he is not exempt because his objection is not based on "established tenets or teachings . . . of a recognized religious sect or division." Moreover, the fact that he is Jewish born does not qualify him for this exemption.

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[12] Similarly, the Fourth Circuit was wrong in *Liberty University, Inc. v. Lew*, 733 F.3d 72 (4th Cir. 2013).

[13] The Affordable Care Act exemption is not simply a "permissible legislative accommodation of religion," such as the one upheld by the Supreme Court in *Cutter v. Wilkinson*, 544 U.S. 709 (2005), a case involving a challenge to the Religious Land Use and Institutionalized Persons Act of 2000 ("RLUIPA"). RLUIPA does not provide exemptions *per se*, it provides that "[n]o government shall impose a substantial burden on the religious exercise of a person residing in or confined to an institution," unless the burden furthers "a compelling governmental interest," and does so by "the least restrictive means." 42 U.S.C. § 2000cc-1(a)(1)-(2). Consequently, RLUIPA alleviates government-created burdens on private religious exercise in general, and it must be administered neutrally among <u>*all*</u> faiths, unlike the exemption at issue here.

Larson v. Valente, 456 U.S. 228 (1982), is instructive. In *Larson*, the plaintiff challenged the constitutionality of a state charitable contributions statute which exempted from its registration and reporting requirements only those religious organizations that received more than fifty percent of their total contributions from members or affiliated organizations (*n.b.*: the statute did not identify any particular religion or sect). The Court held that the statute violated the Establishment Clause, stating that it "is not simply a facially neutral statute, the provisions of which happen to have a 'disparate impact' upon different religious organizations. On the contrary, [the statute] makes explicit and deliberate distinctions between different religious organizations." *Id*. at 247 n.23. The same is true here. Moreover, for the government to evaluate and thus determine which religious "adherents" qualify for the exemption is itself an excessive entanglement prohibited by the Establishment Clause. *See Lemon v. Kurtzman*, 403 U.S. 602 (1971) (finding excessive entanglement in light of the government's power to evaluate the private institution's financial records).

IV. Plaintiff Will Be Irreparably Harmed without the Injunction.

It is well established that "[t]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976). And "a party alleging a violation of the Establishment Clause *per se* satisfies the irreparable injury requirement of the

preliminary injunction calculus." *Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 304 (D.C. Cir. 2006).

V. The Balance of Hardships Weighs in Favor of Granting the Injunction.

The likelihood of harm to Plaintiff without the injunction is substantial because the injunction would maintain the *status quo*. On the other hand, if Defendants are restrained from enforcing the mandate *against Plaintiff*, they will suffer no harm because the protection of constitutional rights can never harm any of Defendants' legitimate interests. Indeed, Defendants have already exempted countless millions of Americans from the Act and have permitted countless thousands (if not millions) to maintain non-compliant plans "if they like them."

VI. The Public Interest Favors Granting the Injunction.

The impact of the injunction on the public interest turns in large part on whether Plaintiff's rights are violated by the challenged mandate because the "enforcement of an unconstitutional law is always contrary to the public interest." *Gordon v. Holder*, 721 F.3d 638, 653 (D.C. Cir. 2013). Thus, because the mandate is unconstitutional as applied against Plaintiff, it is in the public interest to grant the requested injunction.

CONCLUSION

Plaintiff hereby requests that the court grant his motion and enjoin the enforcement of the mandate pending this appeal.

AMERICAN FREEDOM LAW CENTER

/s/ *Robert J. Muise*
Robert J. Muise, Esq. (D.C. Court Bar No. MI 0052)
P.O. Box 131098
Ann Arbor, Michigan 48113
rmuise@americanfreedomlawcenter.org
Tel: (734) 635-3756

/s/ *David Yerushalmi*
David Yerushalmi, Esq. (D.C. Bar No. 978179)
1901 Pennsylvania Avenue NW, Suite 201
Washington, D.C. 20006
dyerushalmi@americanfreedomlawcenter.org
Tel: (646) 262-0500
Fax: (801) 760-3901

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Plaintiff-Appellant Jeffrey Cutler hereby submits the following certificate pursuant to Circuit Rules 12 and 28(a)(1):

1. Parties and Amici.

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.

Plaintiff-Appellant:

Jeffrey Cutler

Defendants-Appellees:

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

2. Rulings Under Review.

Plaintiff-Appellant is appealing from the order and supporting memorandum opinion of U.S. District Court Judge Colleen Kollar-Kotelly entered on June 25, 2014, granting Defendants-Appellees' motion to dismiss and denying Plaintiff-Appellant's Motion for Partial Summary Judgment and Plaintiff-Appellant's

Renewed Motion for Partial Summary Judgment. The order and supporting memorandum opinion appear on the district court's docket at entries 20 and 21, respectively.

3. Related Cases.

The instant case was never previously before this court or any other court, other than the district court from which this case has been appealed. Plaintiff-Appellant is not aware of any related cases pending at the appellate court level. Two cases pending in the district court below that may involve substantially the same parties (*i.e.*, similar defendants, but not the same plaintiff) and the same or similar issues are as follows:

American Freedom Law Center v. Barack Obama, No. 14-1143 (D.D.C. filed July 4, 2014)

West Virginia v. U.S. Dep't of Health & Human Services, No. 14-1287 (D.D.C. filed July 29, 2014)

Respectfully submitted,

AMERICAN FREEDOM LAW CENTER

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

CERTIFICATE OF SERVICE

I hereby certify that on October 16, 2014, 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. I further certify that four (4) copies of this filing were sent this day via Federal Express overnight delivery to the Clerk of the Court.

AMERICAN FREEDOM LAW CENTER

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

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JEFFREY CUTLER, Plaintiff-Appellant, -v- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants-Appellees.	Appeal No. 14-5183

INDEX OF EXHIBITS

Exhibit 1: Order [Doc. No. 20] & Memorandum Opinion [Doc. No. 21]

Exhibit 2: Declaration of Jeffrey Cutler with Exhibits A through C

EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JEFFREY CUTLER,

Plaintiff,

v.

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

Defendants.

Civil Action No. 13-2066 (CKK)

ORDER
(June 25, 2014)

For the reasons stated in the accompanying Memorandum Opinion, it is, this 25th day of June, 2014, hereby

ORDERED that Defendants' [9] Motion to Dismiss is **GRANTED**; and it is further

ORDERED that Plaintiff's [12] Motion for Partial Summary Judgment is **DENIED**; and it is further

ORDERED that Plaintiff's [18] Renewed Motion for Partial Summary Judgment is **DENIED**; and it is further

ORDERED that this action is hereby dismissed in its entirety; and it is further

ORDERED that the Clerk of the Court shall mail a copy of this Order and the accompanying Memorandum Opinion to Plaintiff at his address of record.

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SO ORDERED.

This is a final, appealable Order.

/s/
COLLEEN KOLLAR-KOTELLY
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JEFFREY CUTLER,

Plaintiff,

v.

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

Defendants.

Civil Action No. 13-2066 (CKK)

MEMORANDUM OPINION
(June 25, 2014)

Plaintiff Jeffrey Cutler brings this action against Defendants the United States Department of Health and Human Services, Sylvia Matthews Burwell, in her official capacity as Secretary of Health and Human Services,[1] United States Department of Treasury, and Jacob Lew, in his official capacity as Secretary of the Treasury (collectively "Defendants"), asserting claims that Congress exceeded its authority under the Commerce Clause when enacting the Patient Protection and Affordable Care Act ("Affordable Care Act" or "the Act"), that the Act violates the First Amendment, and that the Act has been impermissibly altered since its enactment. Currently before the Court is Defendants' [9] Motion to Dismiss, Plaintiff's [12] Motion for Partial Summary Judgment, and Plaintiff's [18] Renewed Motion for Partial Summary Judgment. Upon consideration of the pleadings,[2] the relevant legal authorities, and the

[1] Pursuant to Fed. R. Civ. P. 25(d), Sylvia Matthews Burwell has been automatically substituted for Kathleen Sebelius, whom the parties' pleadings name as Defendant.

[2] Compl., ECF No. [1]; Defs.' Mot. to Dismiss, ECF No. [9] ("Defs.' MTD"); Pl.'s Mot. for Part. Summ. J., ECF No. [12] ("Pl's MPSJ"); Pl.'s Resp. for Mot. to Dismiss, ECF. No. [14] ("Pl.'s Resp."); Defs.' Reply Br., ECF No. [15] ("Defs.' Reply Br."); Pl.'s Resp. to Br., ECF No.

record as a whole, the Court GRANTS Defendants' [9] Motion to Dismiss. Given its ruling on the Motion to Dismiss, the Court DENIES Plaintiff's [12] Motion for Partial Summary Judgment and DENIES Plaintiff's [18] Renewed Motion for Partial Summary Judgment.

I. BACKGROUND

A. Statutory Background

In 2010, Congress enacted the Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Compl. ¶ 1. The purpose of the Act was 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*, --- U.S. ---, ---, 132 S. Ct. 2566, 2580 (2012). A portion of the Act, commonly known as the "individual mandate," requires all nonexempt United States citizens to either obtain "minimal essential" health insurance coverage as defined in the Act or pay a penalty. Compl. ¶ 1; *see also* 26 U.S.C. § 5000A (2010). The Act provides certain exemptions to the individual mandate, including one for persons certified as members of an exempt religion or sect, and for members of a health care sharing ministry. Compl. ¶ 1; *see also* 26 U.S.C. § 5000A(d)(2) (2010).

B. Factual Background

The following facts are taken from the Plaintiff's Complaint and must be accepted as true for purposes of a motion to dismiss. *See Atherton v. D.C. Office of the Mayor*, 567 F.3d 672, 681 (D.C. Cir. 2009). Plaintiff is a citizen of the United States and a permanent resident of the Commonwealth of Pennsylvania. Compl. ¶ 5. In November 2013, Plaintiff won a municipal election in East Lampeter Township, Pennsylvania, and will serve a 4-year term as a result. *Id.* Plaintiff is "lawfully bound to uphold the laws of Pennsylvania, and the United States Government." *Id.* Plaintiff's annual income is such that he is required to file federal tax returns.

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[17] ("Pl.'s Resp. to Br."); Pl.'s Renewed Mot. for Part. Summ. J., ECF No. [18] ("Pl.'s Renewed MPSJ").

Id. Plaintiff is subject to the individual mandate of the Act and cannot claim any exemptions. *Id.* ¶ 15. Specifically, Plaintiff is non-observant in his religion and cannot claim a religious exemption from the individual mandate pursuant to 26 U.S.C. § 5000A(d)(2). *Id.* ¶ 5.

Plaintiff's health insurance was canceled "due to the changes specified by regulations that altered the law as approved." *Id.* ¶ 24. Plaintiff currently is not covered under a plan that meets the requirements of minimal essential coverage. *Id.* ¶ 15. Plaintiff can afford health insurance however, Plaintiff does not "wish[] to be mandated to be covered." *Id.* ¶¶ 5, 15. On January 1, 2014 or at "some other date as altered by decree," Plaintiff will incur penalties for failing to maintain minimum essential coverage. *Id.* ¶ 16.

C. Procedural History

On December 31, 2013, Plaintiff filed suit against Defendants in this Court. Plaintiff argues that the individual mandate of the Affordable Care Act is unconstitutional on its face and as applied to him and his constituents. Plaintiff asserts three specific claims in his Complaint: (1) Congress does not have the authority to enact the individual mandate or provide the religious exemption under its Commerce Clause powers, Compl. ¶¶ 30-33; (2) the religious exemption to the individual mandate violates the First Amendment by favoring one religion over another and allowing the government to certify who qualifies for the exemption based on religion, Compl. ¶¶ 1, 30, 32, 33; and (3) alterations to the Act since its passage violate 42 U.S.C. § 18112, Compl. at 11.

Accordingly, Plaintiff requests that the Court issue a declaratory judgment that the individual mandate of the Affordable Care Act exceeds Congress' authority under the Commerce Clause, Art. I, § 8, cl. 3. Compl. at 10-11. Plaintiff also requests a declaratory judgment that the entirety of the Affordable Care Act is invalid because the individual mandate is an integral

component of the Act. *Id.* 11. Plaintiff also seeks a permanent injunction enjoining Defendants and their agents, representatives and employees from giving effect to the Affordable Care Act, because the government's alterations to the law violate 14 U.S.C. § 18112. *Id.*

In response to this Complaint, Defendants filed their [9] Motion to Dismiss, contending that Plaintiff lacks Article III standing to bring this Complaint and contending that Plaintiff failed to state a viable Establishment Clause claim.

In addition to the Complaint, Plaintiff filed his [12] Motion for Partial Summary Judgment, requesting that the Court enter a permanent injunction enjoining Defendants from enforcing the Affordable Care Act, and delay all parts of the Act that have an effective date of January 1, 2014, or later, because the Act violates the Equal Protection Clause.[3] Plaintiff also filed a [18] Renewed Motion for Partial Summary Judgment with his response to Defendants' Motion to Dismiss.

II. LEGAL STANDARD

A. Motion to Dismiss under Rule 12(b)(1)

To survive a motion to dismiss pursuant to Rule 12(b)(1), the plaintiff bears the burden of establishing that the Court has subject matter jurisdiction over its claim. *Moms Against Mercury v. FDA*, 483 F.3d 824, 828 (D.C. Cir. 2007). In determining whether there is jurisdiction, the Court may "consider the complaint supplemented by undisputed facts evidenced in the record, or

[3] Plaintiff alleges that he brings this claim under the Fourteenth Amendment. Pl's MPSJ at 2. However, since Plaintiff sues only federal and not state actors in their official capacities, it is clear that he brings no valid claims pursuant to the Fourteenth Amendment of the United States Constitution: "No *State* shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV (emphasis added). This Court shall treat this as a claim brought under the Fifth Amendment. *See Klayman v. Zuckerberg*, Civ. No. 13-7017, 2014 WL 2619847, at *2 (D.C. Cir. June 13, 2014) ("Normally we afford a liberal reading to a complaint filed by a *pro se* plaintiff.").

the complaint supplemented by undisputed facts plus the court's resolution of disputed facts." *Coal. for Underground Expansion v. Mineta*, 333 F.3d 193, 198 (D.C. Cir. 2003) (citations omitted). "At the motion to dismiss stage, counseled complaints, as well as *pro se* complaints, are to be construed with sufficient liberality to afford all possible inferences favorable to the pleader on allegations of fact." *Settles v. U.S. Parole Comm'n*, 429 F.3d 1098, 1106 (D.C. Cir. 2005). "Although a court must accept as true all factual allegations contained in the complaint when reviewing a motion to dismiss pursuant to Rule 12(b)(1)," the factual allegations in the complaint "will bear closer scrutiny in resolving a 12(b)(1) motion than in resolving a 12(b)(6) motion for failure to state a claim." *Wright v. Foreign Serv. Grievance Bd.*, 503 F. Supp. 2d 163, 170 (D.D.C. 2007) (citations omitted).

B. Motion to Dismiss under Rule 12(b)(6)

Fed. R. Civ. P. 12(b)(6) requires that a complaint contain "'a short and plain statement of the claim showing that the pleader is entitled to relief,' in order to 'give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.'" *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (quoting *Conley v. Gibson*, 355 U.S. 41, 47 (1957)); *accord Erickson v. Pardus*, 551 U.S. 89, 93 (2007) (*per curiam*). Although "detailed factual allegations" are not necessary to withstand a Rule 12(b)(6) motion to dismiss, to provide the "grounds" of "entitle[ment] to relief," a plaintiff must furnish "more than labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Id.* at 555. "[A] complaint [does not] suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550 U.S. at 557). Rather, a complaint must contain sufficient factual matter, accepted as true, to "state a claim to relief that is plausible on its face." *Twombly*, 550 U.S. at 570. "A claim has facial plausibility when the plaintiff pleads

factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678.

In evaluating a Rule 12(b)(6) motion to dismiss for failure to state a claim, the court must construe the complaint in a light most favorable to the plaintiff and must accept as true all reasonable factual inferences drawn from well-pleaded factual allegations. *In re United Mine Workers of Am. Employee Benefit Plans Litig.*, 854 F. Supp. 914, 915 (D.D.C. 1994). Further, the Court is limited to considering the facts alleged in the complaint, any documents attached to or incorporated in the complaint, matters of which the court may take judicial notice, and matters of public record. *See EEOC v. St. Francis Xavier Parochial Sch.*, 117 F.3d 621, 624 (D.C. Cir. 1997). "This includes documents . . . that are referred to in the complaint and [] central to the plaintiff's claim." *Long v. Safeway, Inc.*, 842 F. Supp. 2d 141, 144 (D.D.C. 2012) (internal alteration and citation omitted).

III. DISCUSSION

A. Article III Standing

"To satisfy the requirements of Article III standing in a case challenging government action, a party must allege an injury in fact that is fairly traceable to the challenged government action, and 'it must be likely, as opposed to merely speculative, that the injury will be 'redressed by a favorable decision.'" *National Wrestling Coaches Ass'n. v. Dep't of Educ.*, 366 F.3d 930, 937 (D.C. Cir. 2004) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (internal quotation marks omitted)). It is axiomatic that the "party invoking federal jurisdiction bears the burden of establishing these elements" of constitutional standing. *Lujan*, 504 U.S. at 561. As the Supreme Court has explained:

> We have no power *per se* to review and annul acts of Congress on the ground that they are unconstitutional. The question may be considered only when the justification for some direct injury suffered or threatened, presenting a justiciable

> issue, is made to rest upon such an act. . . . The party who invokes the power must be able to show not only that the statute is invalid but that he has sustained or is immediately in danger of sustaining some direct injury as the result of its enforcement, and not merely that he suffers in some indefinite way in common with people generally.

Hein v. Freedom from Religion Found., Inc., 551 U.S. 587, 599 (2007) (quoting *Massachusetts v. Mellon*, 262 U.S. 447, 488 (1923)).

Here, Plaintiff seeks to bring his complaint on his own behalf as well as on behalf of his constituents in his capacity as a recently elected official in his municipality. Compl. ¶ 1. The Court shall separately address Plaintiff's standing to bring the claim as an elected official and as an individual. For the reasons described herein, the Court concludes that Plaintiff does not have standing to bring this suit in either capacity.

a. Standing as an Elected Official

Plaintiff makes two arguments to support his claim for standing as an elected official. First, Plaintiff seeks to bring his Complaint on behalf of his constituents in his role as their representative. Compl. ¶ 1. Plaintiff also seeks to bring this challenge in his capacity as an elected official based on the notion that the Act will harm his reputation among his constituents. Compl. ¶ 26.

A narrow avenue for standing has been recognized when a legislator seeks to challenge a Congressional act on the basis that the act has diminished his power in his capacity as an elected official. *See Raines v. Byrd*, 521 U.S. 811 (1997); *Coleman v. Miller*, 307 U.S. 433 (1939). In *Coleman v. Miller*, the Court held that state legislators who voted against the ratification of an amendment to the United States Constitution had standing to challenge the ratification of the amendment after the state's Lieutenant Governor cast the deciding vote. 307 U.S. at 438. The Court later clarified that its holding in *Coleman* stands "for the proposition that legislators whose

votes would have been sufficient to defeat (or enact) a specific legislative act have standing to sue if that legislative action goes into effect (or does not go into effect), on the ground that their votes have been completely nullified." *Raines*, 521 U.S. at 823. In *Raines v. Byrd*, the Court emphasized that, in actions brought by legislators, "plaintiff's complaint must establish that he has a 'personal stake' in the alleged dispute, and that the alleged injury suffered is particularized as to him." *Id.* at 819 (holding that members of Congress did not have standing to challenge the Line Item Veto Act passed by Congress that gave the President power to cancel items in any bill). Accordingly, congressional standing may be appropriate in the very limited situation where an elected official has no legislative remedy to correct an alleged injury to his own power as a legislator. *Campbell v. Clinton*, 203 F.3d 19, 22-23 (D.C. Cir. 2000), *cert. denied*, 531 U.S. 815 (2000) (holding that U.S. Congressmen did not have standing to obtain a declaratory judgment that the President's use of forces in Yugoslavia violated the War Powers Clause and the War Powers Resolution because the legislators had other remedies available, including passing a law to forbid the objected-to use of forces); *see Kucinich v. Obama*, 821 F. Supp. 2d 110, 120 (D.D.C. 2011) (noting that "nullification" of votes, and not general, institutional injury, is required to establish injury sufficient to find legislator standing).

Other courts have declined to carve out an exception to *Raines* to extend standing to elected officials who seek to bring claims in their representational capacity as trustees of their constituents, rather than in their legislative capacity. *Ctr. for Biological Diversity v. Brennan*, 571 F. Supp. 2d 1105, 1128 (N.D. Cal. 2007) (holding that *Raines* barred a U.S. Senator and a U.S. Representative from establishing standing in their representational capacity to intervene in a case involving a claim brought by three environmental groups alleging that certain officials failed to comply with provisions of the Global Change Research Act); *Kuchinich v. Def. Fin. &*

Accounting Serv., 183 F. Supp. 2d 1005, 1010 (N.D. Ohio 2002) (holding that a U.S. Representative did not have standing in his representational capacity to bring a claim that the Department of Defense violated a federal law and the U.S. Constitution by awarding a particular contract to a private group). Courts have found that a legislator seeking to bring claims on behalf of his constituents based solely on the fact that he is an elected official fails to meet the requirement that the party has a personal stake in the alleged dispute. *Ctr. for Biological Diversity*, 571 F. Supp. 2d at 1128; *Kuchinich*, 183 F. Supp. 2d at 1009-10.

Here, Plaintiff is unable to, and does not, claim that there is an injury to his legislative power as an elected official within the holding of *Coleman*. The Affordable Care Act was enacted by Congress in 2010. Compl. ¶ 1. Plaintiff was not elected as an official in his municipality until 2013, three years after the Act was passed, and never had the authority to vote on the Act in the first place because he is a local official, not a member of Congress. Plaintiff attempts to bring this Complaint on behalf of his constituents in his representational capacity as an elected official bound by oath to uphold the law. *Id.* Plaintiff's claim for establishing standing on behalf of his constituents appears to be that his constituents will be subject to the individual mandate. In this regard, Plaintiff has failed to establish an alleged injury particularized to him or his constituents, but instead asserts that a generalized injury is shared equally by all citizens. Plaintiff, his constituents, and all nonexempt citizens are subject to the individual mandate. *See Warth v. Seldin*, 422 U.S. 490, 499 (1975) ("When the asserted harm is a 'generalized grievance' shared in substantially equal measure by all or a large class of citizens, that harm alone normally does not warrant exercise of jurisdiction."). Accordingly, Plaintiff has failed to allege any injury that is particularized as to him as an elected official in his representational capacity.

Plaintiff further asserts that he is injured by the individual mandate because he fears that his "personal and professional reputation will be tarnished due to the penalties his constituents will face if they fail to purchase government-mandated health insurance." Compl. ¶ 26. To satisfy his burden, Plaintiff cannot rest on "mere allegations" and must set forth specific facts. *Dominguez v. UAL Corp.*, 666 F.3d 1359, 1362 (D.C. Cir. 2012). The Court is not persuaded by the speculative statement that his personal and professional reputation will be harmed. Plaintiff sets forth no specific facts indicating that he has suffered any sort of reputational injury due to the passage of the Act and only appears to assert that he may suffer some sort of reputational injury at some point in the future. *Public Citizen, Inc. v. Nat'l Highway Traffic Safety Admin.*, 489 F.3d 1279, 1292 (D.C. Cir. 2007) (citing *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990)) (noting that the alleged injury must be concrete in the "qualitative and temporal sense"). Plaintiff has failed to establish that such a loss to his reputation is actual or imminent, as opposed to conjectural or hypothetical. Accordingly, the Court finds that Plaintiff has failed to establish standing to raise his claims in his capacity as an elected official because he has failed to establish an injury-in-fact.

b. Standing as an Individual

The Court now turns to the issue of whether Plaintiff has standing to bring this claim on his own behalf. *See, e.g.*, *Mendoza v. Perez*, Civ. No. 13-5118, 2014 WL 2619844, at *3 (D.C. Cir. June 13, 2014) ("To establish jurisdiction, the court need only find one plaintiff who has standing."). Plaintiff's alleged injuries as a citizen can be broken down into two separate assertions. First, Plaintiff is subject to the individual mandate and must either acquire health insurance or pay the penalty for failing to acquire health insurance. Compl. ¶¶ 15-16. Plaintiff describes this injury as "depriv[ation] . . . of personal property (i.e., personal funds) . . . and of

the liberty to remain a nonparticipant in the health insurance market in violation of the Constitution." Compl. ¶ 27. Second, Plaintiff claims that the religious exemption to the individual mandate violates the First Amendment by allowing the government to "regulate and track a person's religion, and . . . to favor one religion over another." Compl. ¶ 1. Plaintiff further asserts that "[e]mpowering the Internal Revenue Service to be the judge of how religious someone is by 'CERTIFYING' they are the correct religion or sect, damages everyone." Pl.'s Resp. at 3. Defendants allege that Plaintiff fails to meet all three elements required for Article III standing, namely injury, causation, and redressability, in order bring the claim on his own behalf. Defs.' MTD at 7-9. In challenging Plaintiff's standing to bring the instant action, Defendants claim that Plaintiff has not established that he is injured in any way, only that he has a generalized grievance that he does not want to be subject to the individual mandate. *Id.* at 7-9. Further, Defendants assert that Plaintiff's alleged injury cannot be traced to the religious exemption nor redressed by a favorable decision in the instant action. Defendants argue that even if the religious exemption was declared invalid, Plaintiff would still be required to either obtain minimum essential coverage or pay the tax penalty. *Id.* at 9-10. Finally, while Plaintiff also appears to claim that the amendments to the Act since its passage violate 42 U.S.C. § 18112, and that the Act violates the Equal Protection Clause of the Fifth Amendment, Plaintiff makes no claim as to how he is injured by either of these alleged violations.[4] Accordingly, the Court shall address only the injuries cited by Plaintiff.

[4] To the extent that Plaintiff appears to take issue with subsequent amendments to the Act after its passage, Plaintiff has not presented any assertions as to how he is harmed by the amendments to the Act or how the amendments violate the law. *See* Pl.'s MPSJ at 2. Similarly, Plaintiff has made no claim as to how he is injured by the alleged fact that the Act will be enforced differently in different states. *See id.* Accordingly, the Court finds that Plaintiff has failed to meet his burden of establishing standing for these claims.

The Court first turns to the alleged injury that Plaintiff incurs as a citizen subject to the individual mandate: he must either obtain health insurance or pay the penalty. An injury-in-fact must be: (1) concrete; (2) particularized; and (3) actual and imminent. *Public Citizen, Inc. v. Nat'l Highway Traffic Safety Admin.*, 489 F.3d 1279, 1292 (D.C. Cir. 2007) (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)). Here, Plaintiff currently is not covered by a plan that meets the minimum requirements of the Act and does not want to obtain a plan. As a result, Plaintiff will be subject to a penalty. "[Plaintiff] must be able to show . . . that he has sustained . . . some direct injury . . . and not merely that he suffers in some indefinite way in common with people generally.'" *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 345 (2006) (quoting *Doremus v. Bd. of Educ.*, 342 U.S. 429, 434 (1952)). Plaintiff in the instant action only establishes that he is subject to the individual mandate along with all other nonexempt individuals; he has claimed no actual injury that is personalized to him. Plaintiff does not allege that he personally is subject to an economic or other hardship as a result of the individual mandate. Rather, Plaintiff acknowledges that he is financially stable and can afford health insurance coverage if he decided to obtain it. He simply would prefer not to obtain coverage or pay the penalty. Compl. ¶ 5. Defendants argue that this complained injury is "one that applies equally to every citizen, and thus is a generalized grievance insufficient to confer standing . . . ." Defs.' MTD at 6. The Court agrees. Plaintiff's claimed injury, "depriv[ation] . . . of personal property (i.e., personal funds) . . . and of the liberty to remain a nonparticipant in the health insurance market in violation of the Constitution," only establishes that Plaintiff is in the same position as all other nonexempt persons subject to the individual mandate. Compl. ¶ 27.

Another court in this district addressed the same question of standing in *Association of American Physicians & Surgeons v. Sebelius*, 901 F. Supp. 2d 19 (D.D.C. 2012), *aff'd*, 746 F.3d

468 (D.C. Cir. 2014). The court held that two associations had standing to challenge the individual mandate of the Act after members of the association provided declarations indicating that they were subject to the individual mandate and were "harmed financially" as a result. *Id.* at 36. However, the court declined to find that the plaintiffs established injury through a declaration asserting that members opposed the individual mandate but not citing any economic harms as a basis for the general opposition. *Id.* at 35-36. As the court noted, "[g]eneral opposition to a government action is not sufficient injury in fact to confer standing." *Id.* at 36 n.4. Similarly, here, the Court finds that Plaintiff's claimed injury, a general opposition to the individual mandate without any claimed personal injury, is insufficient to establish standing. *See United States v. Hays*, 515 U.S. 737, 743 (1995) ("[W]e have repeatedly refused to recognize a generalized grievance against allegedly illegal governmental conduct as sufficient for standing to invoke the federal judicial power."); *Melcher v. Fed. Open Mkt. Comm.*, 836 F.2d 561, 564 (D.C. Cir. 1987), *cert. denied*, 486 U.S. 1042 (1988) ("Courts are not at liberty to embark upon a broad, undifferentiated mission of vindicating constitutional rights; after all, Article III specifically limits the judicial power of the United States to the resolution of actual cases or controversies.").

The Court next turns to Plaintiff's claim that he is harmed by the religious exemption because the exemption favors one religion over another and allows the government to certify that citizens are the "correct" religion. Defendants argue that Plaintiff has failed to state a concrete and particularized injury as it relates to the religious exemption. Defs.' MTD at 8. Defendants point to the fact that Plaintiff does not claim that he is a member of a group that should be included in the exemption, only that the religious exemption should be declared unconstitutional. *Id.* Based on the fact that Plaintiff does not allege that he should be exempt from the individual

mandate based on his religious beliefs, Defendants claim "Plaintiff's true 'injury' is simply that he disagrees with the minimum coverage provision and would prefer to be exempt." *Id.* In response, Plaintiff claims that the religious exemption "regulate[s] and track[s] a person's religion, and . . . favor[s] one religion over another," and, as result, everyone is harmed. Compl. ¶ 1; Pl.'s Resp. 3. Plaintiff further alleges that "[t]he Commerce Clause gives Congress no authority to mandate a change of religion or punish inactivity, alone." Compl. ¶ 33.

Plaintiff is non-observant in his religion and does not assert that a religious exemption should be extended to him. *See* Compl. ¶ 5. Rather, Plaintiff explains "that he should not be forced to change his religion or religious designation to avoid penalties specified by a law that keeps changing by decree." *Id.* ¶ 25. The allegation that Plaintiff is being "forced" to change his religion is not supported in any other way. Instead, Plaintiff's argument is as follows: there is an exemption to the individual mandate for certain religious groups, he is not a member of any of those groups, and, therefore, he is not able to claim that exemption. It follows that Plaintiff's challenge to the religious exemption solely is based on the general existence of the exemption and not on the exemption's specific application to him.

The Supreme Court has denied citizens and taxpayers standing to raise a generalized grievance about the conduct of government. *Schlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 216-23, 222 n.11 (1974) (quoting *Sierra Club v. Morton*, 405 U.S. 727 (1972) ("We have expressed apprehension about claims of standing based on 'mere interest in a problem.'"). In the instant matter, Plaintiff bases his challenge to the religious exemption on the fact that such exemptions harm everyone by their mere existence and not that the exemption personally harms him. *See* Pl.'s Resp. 3. However, "an asserted right to have the Government act in accordance with the law is not sufficient, standing alone, to confer jurisdiction on a federal

court." *Allen v. Wright*, 468 U.S. 737, 754 (1984). In regards to the religious exemption, Plaintiff has asserted no more than a general claim that Congress has violated the Commerce Clause and the First Amendment. He has asserted no personal stake in the outcome of the controversy as it relates to the religious exemption, or direct injury in order to establish standing. *Hein v. Freedom from Religion Found., Inc.*, 551 U.S. 587, 598 (2007) (noting that the determination of standing is especially important when parties assert an injury that is not distinct from one suffered equally by all taxpayers and citizens); *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 345 (2006) (explaining that a taxpayer must demonstrate a direct injury in order to establish standing).

Defendants also argue that Plaintiff has failed to establish that his alleged injury is traceable to the religious exemption and that the alleged injury can be redressed by declaring the religious exemption invalid. Defs.' MTD at 9-10. Indeed, "'[t]he desire to obtain [sweeping relief] cannot be accepted as a substitute for compliance with the general rule that the complainant must present facts sufficient to show that his individual need requires the remedy for which he asks.'" *Schlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 221-22 (1974) (quoting *McCabe v. Atchison, T. & S. F. R. Co.*, 235 U.S. 151, 164 (1914)). Plaintiff does not seek to have the religious exemption altered to include him, but rather seeks to have the exemption declared as invalid. The Court agrees that the existence of the religious exemption is not traceable to Plaintiff's injury because his real injury is a general grievance with the individual mandate. Further, even if the Court were to find that religious exemption violated the exercise of Congress' Commerce Power in violation of the First Amendment, Plaintiff would be in the same position. He would be subject to the individual mandate and would be required to either obtain health insurance coverage or pay the penalty. The only difference would be that no

one else could claim a religious exemption. Accordingly, Plaintiff's injury, the fact that he is subject to the individual mandate, is not redressed by declaring the religious exemption invalid. Plaintiff seems to imply that if the Court were to declare the religious exemption unconstitutional that it would follow that the Court would have to declare the individual mandate and the entire Act invalid. Compl. ¶ 20-21. Plaintiff has provided no rationale for why this would be the case and the Court does not adopt this view. Accordingly, the Court concludes that Plaintiff has failed to establish that he has standing to bring the instant action and Defendants' Motion to Dismiss shall be granted.

B. Establishment Clause Claim

The Court generally would not address Defendants' contention that Plaintiff failed to state a viable Establishment Clause claim given the Court's finding that Plaintiff does not have standing to bring the instant action. *See Dominguez v. UAL Corp.*, 666 F.3d 1359, 1361-62 (D.C. Cir. 2012) (noting that standing is a required "predicate to any exercise of [the court's] jurisdiction"). However, given the evolution of the taxpayer standing doctrine, *see Hein v. Freedom from Religion Found., Inc.*, 551 U.S. 587, 604 (2007), and in an abundance of caution, the Court shall address Plaintiff's claim that the religious exemption to the individual mandate violates the Establishment Clause by giving preference to one religion over another and allowing the government to certify that members of certain religions are exempt from the individual mandate.[5] Compl. ¶¶ 1, 30, 32, 33; Pl.'s Resp. Br. ¶ 1. Defendants argue that Plaintiff failed to make any sort of factual assertions to establish the necessary elements of an Establishment Clause claim. Defs.' MTD at 11.

[5] The Court shall not address the merits of Plaintiff's other claims because of its finding that Plaintiff does not have standing.

In regards to the Religion Clauses of the First Amendment, the Court has long recognized that there are some actions that are "permitted by the Establishment Clause but not required by the Free Exercise Clause." *Locke v. Davey*, 540 U.S. 712, 718 (2004) (noting that there "is room for play in the joints" of the two clauses). In an Establishment Clause challenge, "the initial inquiry is whether the law facially differentiates among religions." *Chaplaincy of Full Gospel Churches v. United States Navy*, 738 F.3d 425, 430 (D.C. Cir. 2013), *petition for cert. filed*, --- U.S.L.W. --- (May 23, 2014) (No. 13-1419) (citing *Larson v. Valente*, 456 U.S. 228 (1982)). If the law is facially neutral, the court applies the three-part test from *Lemon v. Kurtzman*, 403 U.S. 602 (1971). *Chaplaincy of Full Gospel Churches*, 738 F.3d at 430. The Affordable Care Act provides a "religious conscience" exemption[6] and a "health care sharing ministry" exemption[7] to the individual mandate. The application of the *Lemon* test is appropriate to the religious exemption because neither provision makes "explicit and deliberate distinctions" between different religions or sects.

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[6] This provision provides an exemption for: "a member of a recognized religious sect or division thereof which is described in section 1402(g)(1)"; or "an adherent of established tenets or teachings of such sect or division as described in such section." 26 U.S.C. § 5000A(d)(2)(A). 26 U.S.C. § 1402(g)(1) codifies the religious conscience exemption of the Social Security Amendments of 1965.

[7] This exemption excludes members of a health care sharing ministry, meaning an organization:

> (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
>
> (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,
>
> (III) members of which retain membership even after they develop a medical condition,
>
> (IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and
>
> (V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

26 U.S.C. § 5000A(d)(2)(B). 26 U.S.C. § 501 provides tax exemptions for certain organizations.

The *Lemon* test provides that a law must: "(1) have a secular legislative purpose; (2) have a principal or primary effect that neither advances nor inhibits religion; and (3) not result in excessive entanglement with religion or religious institutions." *Chaplaincy of Full Gospel Churches*, 738 F.3d at 430 (quoting *Bonham v. D.C. Library Admin.*, 989 F.2d 1242, 1244 (D.C. Cir. 1993)). The constitutionality of the religious exemption recently was addressed by the U.S. Court of Appeals for the Fourth Circuit in *Liberty University, Inc. v. Lew*, 733 F.3d 72 (4th Cir. 2013), *cert. denied*, --- U.S. ---, 134 S. Ct. 683 (2013), and is instructive in this matter. In *Liberty University*, the Fourth Circuit held both provisions of the religious exemption passed muster under the *Lemon* test. First, the court found that the religious exemption has a secular legislative purpose: "'to ensure that all persons are provided for, either by the [Act's insurance] system or by their church." *Id.* at 101-02. Second, the court found that the religious exemption had the principal or primary effect of ensuring that all individuals were covered, rather than advancing or inhibiting religion. *Id.* at 102. Finally, the court found that there was no excessive entanglement with religion. *Id.* Here, the Court adopts the reasoning of the Fourth Circuit in noting that Plaintiff failed to state an Establishment Clause claim upon which relief can be granted.[8]

IV. CONCLUSION

For the foregoing reasons, the Court GRANTS Defendants' [9] Motion to Dismiss, DENIES Plaintiff's [12] Motion for Partial Summary Judgment, and DENIES Plaintiff's [18]

[8] The Court further notes that the religious conscience exemption of the Act incorporates the same provision of the Social Security Amendments of 1965. 26 U.S.C. §§ 1402(g)(1) & 5000A(d)(2)(A). Courts have consistently upheld this provision. *Droz v. Comm'r*, 48 F.3d 1120, 1124-25 (9th Cir. 1995), *cert. denied*, 516 U.S. 1042 (1996); *Hatcher v. Comm'r*, 688 F.2d 82, 84 (10th Cir. 1979) (*per curiam*); *Jaggard v. Comm'r*, 582 F.2d 1189, 1189-90 (8th Cir. 1978) (per curiam), *cert. denied*, 440 U.S. 913 (1979).

Renewed Motion for Partial Summary Judgment. An appropriate Order accompanies this Memorandum Opinion.

Dated: June 25, 2014

/s/
COLLEEN KOLLAR-KOTELLY
United States District Judge

EXHIBIT 2

[ORAL ARGUMENT NOT YET SCHEDULED]

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JEFFREY CUTLER, Plaintiff-Appellant, -v- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants-Appellees.	Appeal No. 14-5183

I, Jeffrey Cutler, make this declaration pursuant to 28 U.S.C. § 1746 and based on my personal knowledge and upon verifiable information.

1. I am an adult citizen of the United States, a resident of Pennsylvania, and the Plaintiff-Appellant in this case.

2. I currently serve as the Tax Collector of East Lampeter Township, Lancaster, Pennsylvania, having won the election in November 2013.

3. Pennsylvania is my home, and it is the State in which I wish to reside. I do not want to be forced to move to another State so that I can escape the burdens imposed upon me by the Patient Protection and Affordable Care Act. However, in light of my serious medical condition and the state of my health, I may be forced to do so.

4. I am Jewish by birth. I had relatives who were killed during the Holocaust, and they were killed for no other reason than their Jewish faith. This

tragedy continues to haunt me today, and it fuels my objection to the government declaring through the law which religions may or may not be subject to tax or penalty. That is, I object to the government preferring some religions over others as is the case with the Affordable Care Act.

5. As someone who is Jewish by birth, I am not eligible for an exemption from the mandate to purchase, under penalty, government-approved health insurance as required by the Affordable Care Act. Moreover, my health insurance policy—a policy which I liked, paid for in advance, and wanted to keep—was canceled as a result of the Affordable Care Act, subjecting me to a penalty as a result.

6. I am an engineer by education and training. I have no formal legal education or training.

7. In 2013, I had health insurance through Highmark Blue Shield. I had this policy since 2007. The premium for my health insurance in 2013 was $520.90 per month. I would typically pay my premium six months at a time, and did so in July 2013.

8. I am diabetic and suffer from hypertension. In 2013, my blood pressure medication was not working, and when my blood pressure spiked, I was told to go to the emergency room.

9. In mid-April 2013, I had a heart catheterization and was told that I had

a 100 percent blocked artery and a 70 percent blockage in the artery junction which is commonly known as the "widow maker artery." I was told that the blockage in the artery junction is not suitable for a shunt; therefore, I would need heart bypass surgery.

10. On July 24, 2013 (credited by Highmark on July 29, 2013), I paid $3,000 toward my health insurance premiums to ensure that I would have and retain my current health plan into 2014—a plan which allowed me to see the doctors and receive the treatment that I wanted and needed.

11. On July 25, 2013, I had successful heart bypass surgery. I paid the required deductible and out of pocket expenses and my insurance covered the rest, which was approximately $110,212.75.

12. After receiving an "all clear" from my physician and cardiologist, I started cardiac rehab in Lancaster. My insurance covered 100 percent of each session. I was scheduled to have 36 sessions (2 to 3 per week).

13. On or about October 12, 2013, I received a notice from my insurance company that my health insurance would be terminated on December 31, 2013, as a result of the Affordable Care Act.

14. My health insurance was in fact cancelled on December 31, 2013. Consequently, as of January 1, 2014, I have been without health insurance and thus accruing penalties under the Affordable Care Act. And because my health

insurance was cancelled, I was not able to complete my cardiac rehab sessions.

15. In 2013, President Obama promised the American people that "if you like your health care plan, you can keep it." Even today, the President is assuring the American people that "if you like the insurance you have, keep it," stating that "[n]othing in the proposal forces anyone to change the insurance they have. Period." *See* http://www.whitehouse.gov/health-care-meeting/proposal/titlei/keepit (last visited on Oct. 10, 2014).

16. 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. This "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. A true and correct copy of this letter is attached as Exhibit A.

17. On December 19, 2013, the Center for Consumer Information and Insurance Oversight issued another directive that purportedly 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 Affordable Care Act. This directive states, in part, that "[i]f you have been notified that your policy will not be renewed, you will be eligible for a hardship 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." A true and correct copy of this directive is attached as Exhibit B.

18. I want to keep my healthcare plan—the plan I had since 2007—as President Obama promised, because I like it. The plan provided the coverage I wanted and needed, it allowed me to see the doctors that I preferred, and it was affordable. However, because of the Affordable Care Act, I am unable to keep this plan, and I am subject to penalty as a result.

19. Consequently, on December 31, 2013, I filed this lawsuit on my own behalf (*pro se*) in federal court in Washington, D.C., because I believe that my constitutional rights are being violated by the actions of my federal government—actions which are directly harming me in a very personal way.

20. On March 5, 2014, the Director of the Center for Consumer Information and Insurance Oversight issued a letter confirming the "transitional policy" previously announced by President Obama. A true and accurate copy of this letter is attached as Exhibit C.

21. In the March 5th letter, the Director stated, among other things, "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."

22. The March 5th 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."

23. On September 15, 2014, I attempted to purchase insurance through the Highmark Blue Shield website and over the phone with an associate from Highmark, but was not able to do so because of the Affordable Care Act. And because of the Act, I cannot keep my health insurance policy, despite the President's promise, because Pennsylvania is not one of the States where that is possible.

24. Although the mandate to purchase and maintain government-approved health insurance is a federal mandate that is applicable to all American citizens,

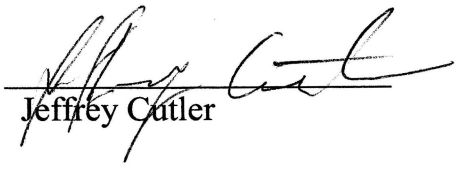
with a few exceptions, the "transitional policy" promised by the President is discriminatorily enforced based upon the State in which a person resides. In Pennsylvania, I cannot keep my health insurance.

25. Indeed, as a result of the Affordable Care Act, I cannot even attempt to get insurance again until November 15, 2014. However, as of January 1, 2014, I have been accruing penalties under the Act.

26. I am an "applicable individual" pursuant to the Affordable Care Act's mandate to purchase insurance. I do not qualify for any statutory exemptions from the mandate or its "penalty." In particular, I do not get a religious exemption from the mandate or its penalty due to the fact that I am Jewish—that was not one of the "certified" religions. And even though I liked the health insurance plan I had in 2013, I was not able to keep it as a result of the Affordable Care Act.

I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

Executed on the 11 day of October, 2014.



Jeffrey Cutler

EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

November 14, 2013

Dear Insurance Commissioners,

Some 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, such as the new modified community rating and essential health benefits package standards.[1] Although 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 they may be dissuaded from immediately transitioning to such coverage.

In light of this circumstance, under the following transitional policy, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under 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 to be out of compliance with the market reforms specified below under the conditions specified below.[2] We will consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe.

The specified market reforms are the portions of the following provisions of the Public Health Service Act that are scheduled to take effect for plan or policy years starting on or after

[1] Health plans that are grandfathered pursuant to section 1251 of the Affordable Care Act and its implementing regulations are not subject to most market reforms. Because there is no need for transitional relief for such plans, the transitional relief afforded in this document is not applicable to grandfathered health plans.

[2] The Department of Health and Human Services has conferred with the Departments of Labor and the Treasury with respect to those market reforms with respect to which there is shared jurisdiction. With respect to those market reforms, the Departments of Labor and the Treasury concur with the transitional relief afforded in this document.

January 1, 2014, and any corresponding portions of the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code):

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);
- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;[3]
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials).

The specified conditions are the following:

- The coverage was in effect on October 1, 2013;[4]
- The health insurance issuer sends a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage, or sends a notice to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage, that informs them of (1) any changes in the options that are available to them; (2) which of the specified market reforms would not be reflected in any coverage that continues; (3) their potential right to enroll in a qualified health plan offered through a Health Insurance Marketplace and possibly qualify for financial assistance; (4) how to access such coverage through a Marketplace; and (5) their right to enroll in health insurance coverage outside of a Marketplace that complies with the specified market reforms. Where individuals or small businesses have already received a cancellation or termination notice, the issuer must send this notice as soon as reasonably possible. Where individuals or small business would otherwise receive a cancellation or termination notice, the issuer must send this

[3] We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plans.

[4] In light of this condition, the transitional relief afforded in this document is not applicable to newly obtained health insurance coverage. It applies only with respect to individuals and small businesses with coverage that was in effect on October 1, 2013; it does not apply with respect to individuals and small businesses that obtain new coverage after October 1, 2013.

notice by the time that it would otherwise send the cancellation or termination notice.

State agencies responsible for enforcing the specified market reforms are encouraged to adopt the same transitional policy with respect to this coverage.

Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance.

Sincerely,

/Signed, GC, November 14, 2013/

Gary Cohen
Director
Center for Consumer Information and Insurance Oversight

EXHIBIT B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: **December 19, 2013**

Subject: **Options Available for Consumers with Cancelled Policies**

The Affordable Care Act provides many new consumer protections. In some instances, health insurance issuers in the individual and small group markets are cancelling policies that do not include the new protections for policy or plan years beginning in 2014. Because some consumers were finding other coverage options to be more expensive than their cancelled plans or policies, President Obama announced a transition period allowing for the renewal of cancelled plans and policies between January 1 and October 1, 2014, under certain circumstances. Some states have adopted the transitional policy, enabling health insurance issuers to renew their existing plans and policies. Some health insurance issuers are not renewing cancelled plans or policies.

To ensure that consumers whose policies are being cancelled are able to keep affordable health insurance coverage, we are reminding consumers in the individual market of the many options already available to them, and we are clarifying another option for consumers in the individual market.

Options for Consumers

If your health insurance policy has been cancelled, a number of options are already available to you:

- You have the chance to buy any of your health insurance issuer's individual market policies available to you in 2014.
- You may shop for coverage through the Health Insurance Marketplace (the Marketplace). Depending on your income and other factors, you may be eligible to receive a premium tax credit that will help cover the cost of purchasing coverage through the Marketplace or cost-sharing reductions for Marketplace coverage. You may also be eligible for Medicaid.
- You can also shop for policies outside the Marketplace. This is a good option if you do not qualify for premium tax credits or cost-sharing reductions based on your income. If you do qualify for premium tax credits or cost-sharing reductions, you can only get such assistance if you enroll through the Marketplace.

If you have been notified that your policy will not be renewed, you will be eligible for a hardship 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. You will then need to 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. For example, you can submit your cancellation letter or some other proof of cancellation. If you are applying for catastrophic coverage from the same issuer that cancelled your previous policy, the issuer may be able to confirm that based on its internal records. You may then purchase catastrophic coverage from that issuer. Your issuer will send these items to CMS, and CMS will verify that you were eligible for this hardship exemption. If you are not able to submit supporting documentation at the time you submit the exemption form, CMS will contact you to let you know your application is incomplete and cannot be processed until you submit supporting documentation of your previous policy's cancellation. If you are interested in pursuing this option, and you need assistance, please call the call center at: 1-866-837-0677.

EXHIBIT C

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: March 5, 2014

From: Gary Cohen, Director, Center for Consumer Information and Insurance Oversight

Title: Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016

Subject: Extended Transition to Affordable Care Act-Compliant Policies

On November 14, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a letter to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. CMS announced in its November 14, 2013 letter that, if permitted by applicable State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS further stated that, under the transitional policy, non-grandfathered 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 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met.

As provided in the November 14, 2013 letter, policies subject to the transitional relief are not considered to be out of compliance with the following provisions of the Public Health Service Act (PHS Act):

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);
- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;[1]
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);

[1] We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plan coverage.

- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials);

Additionally, policies subject to the transitional relief are not considered to be out of compliance with section 1312(c) of the Affordable Care Act (relating to the single risk pool requirement). As a reminder, issuers can choose to adopt one or all of these provisions in their renewed policies.

CMS indicated in its November 14, 2013 letter that it would consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe. 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. We will consider the impact of the two-year extension of the transitional policy in assessing whether an additional one-year extension is appropriate.

This policy also applies to large businesses that currently purchase insurance in the large group market but that, as of January 1, 2016, will be redefined by section 1304(b) of the Affordable Care Act as small businesses purchasing insurance in the small group market. At the option of the States and health insurance issuers, they, too, will have the option of renewing their current policies through policy years beginning on or before October 1, 2016, without their policies being considered to be out of compliance with the provisions specified above that apply to the small group market but not to the large group market.

At the option of the States, health insurance issuers that have issued or will issue a policy under the transitional policy anytime in 2014 may renew such policies at any time through October 1, 2016, and affected individuals and small businesses may choose to re-enroll in such coverage through October 1, 2016.

States that did not adopt the November 14, 2013 transitional policy, and that regulate issuers whose 2013 policies renew anytime between the date of issuance of this bulletin and December 31, 2014, including any policies that they allowed to be renewed early in late 2013, may choose to implement the transitional policy for any remaining portion of the 2014 policy year (i.e., this policy could apply to "early renewals" from late 2013). Moreover, States can elect to extend the transitional policy for a shorter period than through October 1, 2016 (but may not extend it to policy years beginning after October 1, 2016).

Furthermore, States may choose to adopt both the November 14, 2013 transitional policy as well as the extended transitional policy through October 1, 2016, or adopt one but not the other, in the following manner:

- For both the individual and the small group markets;
- For the individual market only; or
- For the small group market only.
- A State may also choose to adopt the transitional relief policy only for large businesses that currently purchase insurance in the large group market but that, for policy years beginning on or after January 1, 2016, will be redefined as small businesses purchasing insurance in the small group market.

Under the extended transitional policy, health insurance coverage in the individual or small group market that meets the criteria of the extended transitional policy through October 1, 2016, and associated group health plans of small businesses, as applicable, will not be considered to be out of compliance with the market reforms as specified above. Health insurance issuers that renew coverage under this extended transitional policy through October 1, 2016, must, for each policy year, provide the relevant attached notice to affected individuals and small businesses as specified in our November 14, 2013 guidance.[2]

All transitional policies that have rate increases subject to review under PHS Act section 2794 should utilize the rules and processes for submission to States and CMS that were in place prior to April 1, 2013, to assure compliance with PHS Act section 2794 requirements.

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.[3] 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.

Where to get more information:

If you have any questions regarding this guidance, please e-mail CCIIO at marketreform@cms.hhs.gov.

[2] Because these are required standard notices that cannot be modified, the Paperwork Reduction Act does not apply to these notices.

[3] The December 19, 2013 guidance can be found here: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf.

Attachment 1

This notice must be used when a cancellation notice has already been sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We previously notified you that your current policy is being cancelled because it does not meet the minimum standards required by the Affordable Care Act. We are now writing to inform you that, consistent with federal guidance initially announced in November 2013, and extended in March 2014, you may keep this coverage for the upcoming policy year.

How Do I Keep My Current Policy?

To keep your current policy, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it may NOT provide all of the protections of the Affordable Care Act. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

- May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).
- May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).
- May not meet standards for guaranteed renewability (PHS Act section 2703).
- If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).
- If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).
- May not meet standards for non-discrimination with respect to health care providers (PHS Act section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs or maternity care, or might have unlimited cost-sharing (PHS Act section 2707).

- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709).

How Do I Choose A Different Policy?

You have options for getting quality health insurance. [You may shop in the Health Insurance Marketplace, where all policies meet certain standards to help guarantee health care security, and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing medical condition. The Marketplace allows you to choose a private policy that fits your budget and health care needs. You may qualify for tax credits or other federal financial assistance to help you afford health insurance coverage purchased through the Marketplace.][4]

[You can also get new health insurance outside the Marketplace.] All new policies guarantee certain protections, such as your ability to buy a policy even if you have a pre-existing medical condition. [However, federal financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, because you may have to buy your coverage within a limited time period.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596 **or TTY: 1-855-889-4325.**

If you have questions, please contact us.

[4] The bracket language does not apply to the U.S. territories that do not have a Marketplace.

Attachment 2

This notice must be used when a cancellation notice has not yet been sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We are writing to inform you that, consistent with federal guidance initially announced in November 2013 and extended in March 2014, you may keep your existing coverage for the upcoming policy year.

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