Health Care Reform in the Federal Courts

Earlier this year, Congress passed the Patient Protection and Affordable Care Act of 2010, described by many as the most sweeping overhaul of health care financing in our nation's history. Individuals, families, and businesses will be affected in new and complex ways. Fundamental legal questions, including constitutional challenges, are currently eclipsing the promulgation of rules to implement the new law, and decisions of the federal courts will be central to the evolution of reform. Attorneys, including those who rarely work in health care, need to be informed as advisors and advocates, and as citizens. Tracking the process through our federal courts may be the best way to ensure that.

By Robert R. Harrison

With the passage of the Patient Protection and Affordable Healthcare Act of 2010 and the Healthcare and Education Reconciliation Act of 2010 (collectively PPACA), Congress enacted sweeping legislation that is likely to generate litigation in the federal courts for years to come. Regulatory agencies are scrambling to publish rules on an aggressive schedule, but most of the specifics of the new health care legislation remain largely unknown. Although the contours of federal legislation have always been articulated in the federal courts, the current health care reform legislation may be unprecedented in the extent to which the federal courts are involved at such an early stage. Even before the ink was dry on President Obama's signature, Virginia and Florida had filed lawsuits challenging the constitutionality of various provisions of the legislation.[1] With suit now filed in Michigan as well, three lawsuits are before the federal courts, and more are expected to follow.[2] Notably, the three lawsuits arise in separate circuits; the Fourth, Sixth and Eleventh Circuits.

Although these recently filed lawsuits challenging provisions of the legislation will not be decided for some time, and appeals are inevitable, an understanding of the role the federal courts have already played is essential for anyone following the process. Challenges to the constitutionality of PPACA are not the only issues with implications for health care reform that the federal courts have addressed recently. In the last term, the U.S. Supreme Court denied a petition for certiorari on a significant ruling from the Ninth Circuit, upholding the "Healthy San Francisco" employer mandate to provide health care coverage. The Court also issued an opinion addressing severability; this is potentially a key question should some part of PPACA be found unconstitutional. These two Court decisions are judicial bookends for current constitutional challenges to PPACA.

Healthy San Francisco

Before concluding the last term, the Supreme Court denied a petition for certiorari in *Golden Gate Restaurant Association v. City and County of San Francisco, Calif.*,[3] leaving undisturbed a significant Ninth Circuit decision

with implications for other challenges to the 2010 health care reform legislation.

In July 2006, San Francisco's Board of Supervisors enacted the San Francisco Health Care Security Ordinance (HCSO),[4] which is intended to provide health care services for uninsured residents of San Francisco. The legislation created a network of providers in the city of San Francisco who would operate a public health care program, the Health Access Program (HAP), which is funded through a combination of city taxes and payments from employers and individuals. The program is available to any resident of the city of San Francisco who meets certain age and income requirements and lacks health insurance. Of note, the HAP uses the concept of "medical homes" (a feature adopted in federal reform legislation as well), according to which primary care providers plan and oversee care for each enrollee in the program.[5]

The HCSO mandates that covered employers make certain minimum expenditures either to, or on behalf of, covered employees. The amount of minimum health care expenditures employers must undertake is determined by a formula in which the number of employees is multiplied by an hourly rate set by the statute.[6] Health care expenditures include amounts paid as contributions to health savings accounts or other similar accounts, direct reimbursement of health care expenses, payments to insurance companies or other third parties that provide health services, and the costs an employer incurs in providing direct health care services to employees. Employers also have the option—the city payment option—of making a payment directly to the city in lieu of other expenditures.

Although the HAP is primarily funded through city taxes, this "play or pay" mandate imposed on employers is an essential portion of the funding, with political implications very much like those raised in the new federal reform legislation. Simply stated, employers who do not provide adequate health care benefits to their employees (that is, employers who "play") are required to pay a tax or penalty to the city of San Francisco (that is, they must "pay"). Monies raised through the city-payment option are generally used to fund care for eligible employees through the HAP and to fund a reimbursement account for ineligible employees.

The HCSO also includes certain requirements for record keeping and reporting. Employers are required to document expenditures they make on behalf of employees; provide data sufficient for determining the eligibility of employees to participate in the HAP or, in the alternative, their eligibility for a medical reimbursement account; and notify employees in each case in which the employer elects the city-payment option. The requirements for minimum expenditures and record keeping are enforced through a combination of administrative action and monetary penalties.

In November 2006, the Golden Gate Restaurant Association (GGRA), a trade association, brought suit in the U.S. District Court for the Northern District of California on the grounds that the spending requirements imposed by the HCSO are pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA). In a classic pre-emption argument, GGRA argued that the HCSO's spending requirements relate to employee benefit plans within the meaning of ERISA and are therefore pre-empted, because ERISA pre-empts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."[7] Following motions for summary judgment, the district court ruled in favor of Golden Gate Restaurant Association, finding that the HCSO's employer spending requirements impermissibly relate to an ERISA employee benefit plan and are thereby pre-empted.[8] The city of San Francisco asked the district court for a stay of its order pending appeal, but that request was denied. However, the Ninth Circuit granted a stay on Jan. 9, 2008, noting that the city of San Francisco had a likelihood of success on the merits of the question.[9]

The Ninth Circuit reviewed the legal question of ERISA pre-emption de novo.[10] Reversing the district court, the court of appeals noted that five categories of employers are identified under the HCSO: those having no ERISA plan; those with an ERISA plan covering all employees at a rate that is greater than the minimum expenditure required by the ordinance; those with ERISA plan coverage for some employees, but not all; those with ERISA plan coverage for all employees, but at a level that is less than the minimum expenditure required under the HCSO; and those who provide ERISA plan coverage for some employees, but not all, and at a level that is less than the minimum expenditure required.

Noting that San Francisco employers who have no ERISA plan may simply make payments to the city and not create—or face any obligation to create—an ERISA plan and also noting that employers who offer a high-benefit ERISA plan need not change that plan at all, the court found that employers could comply with the spending requirements without creating or changing ERISA plans. The court found that employers in the other three categories could meet their obligations under the HCSO by altering existing ERISA plans or creating new plans, but that nothing in the ordinance requires them to do so. The court also took note that the HCSO does not mandate any aspect of the design or content of the benefit, only the dollar amount that employers must spend.

In what is now a somewhat ironic perspective—given the current broad federal effort to regulate health care—the Ninth Circuit began its pre-emption analysis with the view that health care regulation has always been, and remains, primarily the province of state regulation, not federal regulation, and that ERISA pre-emption is presumed not to extend to "general health care regulation, which historically has been a matter of local concern."[11] The court described the HCSO as a "novel approach to the provision of health services" but one that "operates in a field that has long been the province of state and local governments."

The court of appeals rejected the argument that the record keeping and reporting obligations, which would apply to the city-payment option as well as to any ERISA plan, would in themselves constitute the creation of an ERISA plan. The court found significant the fact that the

employer would have no responsibility other than calculating and making payments and reflecting in the company's records that such payments had been made. Echoing prior decisions, the court noted that more than a modicum of discretion in administrative activity is necessary to constitute an ERISA plan.[12] The court was not persuaded that the administrative activity required by the HCSO rises to the level of an "ongoing administrative scheme" that is essential to the definition of an ERISA plan. The court also observed that the spending requirements of the HCSO would be in full force even if no employer in the city were to have an ERISA plan. Rejecting the district court's conclusion, the Ninth Circuit upheld the Healthy San Francisco program, noting the following: "There may be better ways to provide health care than to require employers in the City of San Francisco to foot the bill. But our task is a narrow one, and it is beyond our province to evaluate the wisdom of the Ordinance before us."

On June 6, 2009, the Golden Gate Restaurant Association filed a petition for certiorari, and on the first Monday in October, the U.S. Supreme Court requested a briefing from the solicitor general of the United States. In an amicus brief submitted in May, Neal Katyal,[13] the acting solicitor general, argued that the Court should not review the pre-emption issue in light of passage of the 2010 health care reform legislation. The solicitor general argued that, because of several provisions of PPACA, it is far less likely that a statute such as the one enacted by the city of San Francisco would be passed elsewhere, substantially eliminating the importance of the question regarding ERISA pre-emption of programs such as the HCSO.

The solicitor general suggested that the contours of the legislation will remain unclear for some time as the three federal agencies (the Departments of Health and Human Services, Labor, and Treasury) that are substantially involved will be promulgating regulations over the next several years. He also pointed to the existence of a savings provision in the health care reform legislation, noting that the courts have not had an opportunity to interpret that savings provision—in particular, the question of whether the provision applies only to legislation enacted by the respective states or more broadly to include state subdivisions.

In denying the petition for certiorari, the Supreme Court avoided handing down an opinion that could have had substantial implications for various federal departments' actions in promulgating regulations and defining the pre-emption analysis for the health care reform legislation. The Court also avoided ruling on pre-emption questions for legislation that is the subject of constitutional challenges that are likely to reach the Court on a petition for review of the inevitable decisions from several courts of appeals.

Constitutional Challenges

Almost half the nation's 50 states have now filed or have joined in challenges to PPACA on constitutional grounds. Although several constitutional questions have been raised, the most consistent argument is that the mandate for individual insurance coverage—PPACA, § 1501, Requirement to Maintain Minimum Essential Coverage—is an unconstitutional expansion of the Commerce Clause. The requirement, codified in a new chapter of Subtitle D of the Internal Revenue Code, mandates that each individual, and any dependent of that individual, be covered under an insurance policy that provides minimum essential coverage and that an individual failing to meet the requirement be assessed a penalty. The penalty is effective for calendar years 2014 and beyond; for 2016 and beyond, the amount of the penalty will be $750, indexed to cost-of-living increases for each successive year.[14]

On March 23, 2010, the attorney general of Virginia filed suit in the U.S. District Court for the Eastern District of Virginia in Richmond—*Commonwealth of Virginia ex rel. Kenneth Ray Cuchinelli v. Kathleen Sebelius*[15]—asking the district Court to declare § 1501 of the PPACA, the individual mandate, unconstitutional, "because the individual mandate exceeds the enumerated powers conferred upon Congress."[16] The complaint asks for an injunction against § 1501 in particular and, on the grounds that there is no severability clause, an injunction against enforcement of PPACA in its entirety. Because Virginia's argument is based on the conflict between PPACA's individual mandate and the newly minted Virginia Health Care Freedom Act,[17] the constitutionality of the federal statute must be addressed in order to resolve the question of whether the Supremacy Clause dictates that Virginia must yield to the federal statute. The existence of that conflict with the Virginia statute makes Virginia's suit somewhat different, but it underscores the federalism issues inherent in the question of whether the PPACA is constitutional.

On May 24, 2010, the secretary of health and human services filed a motion to dismiss pursuant to Rules 12(b)(1) and 12(b)(6), arguing primarily that Virginia does not have standing. Argument on the motion was heard on July 1, 2010, in the U.S. District Court for the Eastern District of Virginia in Richmond. The secretary argued that Virginia cannot sue on behalf of its citizens, citing the parens patriae doctrine of *Massachusetts v. Mellon*, 262 U.S. 447 (1923). Under this doctrine, the secretary argued, a state does not have the power to enforce the rights of citizens in "their relations with the federal government."[18] Virginia countered with the argument that the state is not representing its citizens individually, but rather is exercising its well-established core sovereign power to defend the constitutionality of its laws. Citing *Diamond v. Charles*, 476 U.S. 54 (1986), Virginia argued that, because the state alone has the power to create its state laws, Virginia and only Virginia has standing to defend its legislative enactments.

The secretary of health and human services also argued that the suit is barred by the Anti-Injunction Act, requiring that assessed taxes must be paid before taxpayers have standing to challenge them. This argument required the predicate assertion that the penalty imposed by § 1501 is legally a tax. Although the legislative history and the text of the statute are arguably inconsistent with this assertion, the question was resolved without deciding whether the penalty is a tax. Relying on *Vermont Agency of Natural*

Resources v. United States ex rel. Stevens, 529 U.S. 765, 780 (2000), and other circuit court decisions, Virginia asserted that the use of the term "person" in the Anti-Injunction Act does not include the sovereign, and thus the bar is inapplicable to a state. The court agreed with Virginia's argument.

On Aug. 2, 2010, Judge Henry Hudson denied the motion to dismiss. Stating that the only issue before the court at this stage is the legal sufficiency of the complaint, Judge Hudson found that the "presence of some authority arguably supporting the theory underlying each side's position" required rejection of the argument that the complaint fails to state a cause of action. Although the secretary described the ruling as merely procedural, the court did assess the merits of the arguments to the extent that was necessary to decide whether Virginia's complaint stated a cognizable claim. Even though the court did not weigh the merits of the substantive arguments, it did acknowledge that those arguments had merit, effectively foreclosing, at least for now, arguments that constitutional challenges to the PPACA must fail. Looking at those arguments, as briefed by the parties, is instructive in following the reform debates that the federal courts are being asked to hear.

Commerce Clause

The core of Virginia's argument is that the Commerce Clause, asserted by the Congress as the authority for enacting the individual mandate, has never been and cannot be extended so far as to "require citizens to buy goods or services."[19] Virginia asserts that the decision not to purchase insurance is not economic activity, nor is it noneconomic activity subject to regulation under the Necessary and Proper Clause. Citing *Gonzales v. Raich,* 545 U.S. 1 (2005), Virginia concedes that noneconomic activity that could not otherwise be regulated under the Commerce Clause may be reached through the Necessary and Proper Clause only if the means are appropriate, are 'plainly adapted' to the accomplishment of an enumerated power, and are "consistent with the letter and spirit of the constitution."[20] Virginia argues that the "foundational assumptions of the constitutional compact" are inconsistent with the redistribution of wealth required by § 1501 of the PPACA, and that the individual insurance mandate is "unconstitutional under every ordinary measure of constitutional adjudication."

Virginia argues that, despite affirmative findings in the legislation that Congress was acting under the Commerce Clause, Congress did not adequately address federalism issues. Virginia cited Justice Breyer's dissent in *United States v. Morrison*, 529 U.S. 549 (1995), in which he recognized that the Supreme Court might employ a heightened scrutiny under the Commerce Clause when Congress appeared to have acted in haste or failed to consider federalism issues adequately. Citing *Morrison* and *United States v. Lopez*, 514 U.S. 549 (1995), Virginia argues that an interpretation of the Commerce Clause that "lacks principled limits" cannot be sustained, because it would constitute a de facto national police power. Combining these two threads from *Morrison* and *Lopez*, Virginia argues that upholding this command to engage in economic activity (the purchase of health insurance) and the legislative command to pay a penalty to the Internal Revenue Service would extend the Commerce Clause in a way that is indistinguishable from a national police power.

The secretary of health and human services argues that the collective effect of individual decisions not to purchase health insurance and not to participate in the interstate market for insurance will have an adequate effect on interstate commerce.

The secretary of health and human services disagrees, asserting that, because everyone will eventually need medical services, nobody may elect not to participate in interstate commerce, noting that the Congress made extensive findings that the mandate is central to a complex health care regulatory scheme. The secretary argues that the collective effect of individual decisions not to purchase health insurance and not to participate in the interstate market for insurance will have an adequate effect on interstate commerce.

The secretary argues an aggregation theory derived in substantial measure from *Gonzales v. Raich*. Under *Gonzales*, Congress may regulate an entire class of economic activity if the "total incidence of a practice poses a threat to a national market. …"[21] At oral argument, the secretary asserted that full participation of everyone in the market for health insurance is essential to the financial foundation of the health care system and that, without the individual mandate, the health care system will fail.[22] In an expected reference to *Wickard v. Filburn*, 317 U.S. 111 (1942), the secretary compared the insurance mandate to the upholding of congressional power to regulate the personal consumption of wheat grown on Mr. Filburn's farm. In that reading of the Commerce Clause, the Court found that Mr. Filburn's decision to grow and consume his own wheat removed his demand for wheat from the market, thereby affecting interstate commerce. Virginia, on the other hand, distinguishes *Wickard* and *Gonzales* on the grounds that those two decisions involved economic activity in the sense of a voluntary decision to perform an act, whether the growing of wheat in *Wickard* or the growing of marijuana in *Gonzales*.[23]

Necessary and Proper Clause

Virginia and the secretary of health and human services take different views of the Necessary and Proper Clause, with Virginia rejecting the application of that clause. Acknowledging that the Necessary and Proper Clause may be the grounds for enforcing legislative enactments that would be beyond the power of the Commerce Clause, Virginia notes that there is nevertheless a limit to that power—a limit the Supreme Court recently articulated

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in *United States v. Comstock*, 130 S. Ct. 1949 (2010). In *Comstock*, the Court noted that the scope of the Necessary and Proper Clause is limited by the inquiry "whether the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power or other powers that the Constitution grants Congress the authority to implement."[24] Virginia argues that the Necessary and Proper Clause cannot be used to enforce an unconstitutional exercise of power under the Commerce Clause.[25]

Taxing Power

Despite the Obama administration's emphatic denials during the legislative process, the secretary of health and human services argues that the penalty provision is a tax, consistent with the government's power to tax for the general welfare, and that the power to impose taxes is broader than the power conferred by the Commerce Clause. Citing *McCray v. United States*, 195 U.S. 27 (1904), the secretary argues that the power of Congress to tax under the General Welfare Clause is extensive, even extending to "purposes that would exceed its powers under other provisions of Article 1."[26] The secretary relied on *United States v. Aiken*, 974 F.2d 446, 448 (4th Cir. 1992), for her assertion that the Article I power to collect taxes and duties requires only that the enactment be a revenue-raising measure in which the regulatory provisions bear a reasonable relation to the stated taxing purpose.

Virginia argues that describing the penalty as a tax is inconsistent with historically recognized definitions of a tax, noting that the language of PPACA § 1501 clearly describes the payment as an enforcement penalty imposed under the government's commerce power. At oral argument on the motion to dismiss, Virginia argued that Congress cannot constitutionally "regulate through taxation that which it cannot otherwise regulate."[27] Virginia also identified a kind of paradox in which the secretary asserted the power to raise revenue as the constitutional authority for a statute under which full compliance with the statute (that is, each individual or family purchasing acceptable insurance coverage) would result in the generation of no revenue whatsoever. If everyone complies with the statute, no penalty may be imposed, and no funds will be collected.

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A similar lawsuit was filed on March 23, 2010, by Florida's attorney general, William McCullum, joined by attorneys general from 19 other states. The suit argues that the reform legislation exceeds congressional power under Articles 1 and 4 of the Constitution as well as the Tenth Amendment. Florida argues that the tax or penalty associated with the individual mandate constitutes a capitation and a direct tax not apportioned among the states and that the tax or penalty thereby injures the sovereign interests of the state of Florida. Florida also argues that the legislation cannot be upheld under the Commerce Clause, because it compels persons to perform affirmative acts under pain of a financial penalty with no basis other than the individuals' existence as citizens of the United States. In addition, Florida maintains that the legislation cannot be upheld under the taxing and spending clause, because it "unlawfully coerces persons to obtain healthcare coverage, thereby injuring the [states] because many persons will be compelled to enroll in Medicaid at a substantial cost to [the states]."

On April 6, 2010, the Thomas More Law Center and four individual plaintiffs filed suit in the U.S. District Court for the Eastern District of Michigan asking that the court preliminarily enjoin enforcement of the PPACA on the grounds that the individual mandate is unconstitutional.[29] The plaintiffs make essentially the same Commerce Clause argument as Virginia did, though with greater emphasis on the limits articulated in *Lopez, Morrison*, and *Gonzales*. Conceding that both the health care system and the health insurance market generally may fall within the ambit of interstate commerce, the plaintiffs assert that the question is whether "the federal government has authority under the Commerce Clause to force [individuals] to purchase insurance from specific vendors or suffer the consequences of a federally-imposed penalty."[30]

Severability

Virginia argues that the absence of a severability clause necessarily means that, if § 1501 of the PPACA is found to be unconstitutional, then the entire act must be struck down.[31] In an opinion handed down on June 28, 2010, the U.S. Supreme Court may have cast doubt on that premise. In *Free Enterprise Fund v. The Public Company Accounting Oversight Board*, 561 U.S. __ (2010), the Court was asked to address the constitutionality of a two-layer "for cause" termination provision that allowed an oversight board, which was composed of five members appointed by the Securities and Exchange Commission and over which the President had no direct authority, to remove members of the board.

The Court held that the provision in question was unconstitutional in that it deprived the President of adequate control over the board and therefore interfered with a presidential power that the Congress has no right

to diminish. The Free Enterprise Fund argued that the constitutional infirmity of the tenure provisions rendered the entire act unconstitutional and asked that it be set aside. The Court rejected that argument, despite finding the tenure provisions unconstitutional. Citing a line of established cases, the Court noted that constitutional flaws in legislation are addressed through severing the offending provision while leaving the remainder of the legislation intact, "[u]nless it is evident that the Legislature would not have enacted those provisions … independently of that which is [invalid]."[32] Following the principle that partial invalidation should be preferred over facial invalidation, the Court left the Sarbanes-Oxley Act intact and fully operative, except for the tenure restrictions that had been excised.

Although the Court's decision has nothing explicitly to do with health care reform, the ruling clearly has implications for the argument that the entire reform legislation should be set aside if certain provisions are found unconstitutional. With its holding in *Free Enterprise Fund v. The Public Company Accounting Oversight Board*, the Supreme Court affirmed once again, and in strong language, that it will not invalidate an entire legislative enactment because it finds certain provisions to be unconstitutional. The question is whether the remaining provisions of the PPACA can operate independently if the individual mandate is found unconstitutional. Arguments that the unconstitutionality of § 1501 would render the entire law unconstitutional will need to address this newest guidance provided by the Supreme Court.

Conclusion

Most of the regulations needed to implement the 2010 health care reform legislation have not been published. Indeed, many have not even been written. Whatever the outcome of decisions on the constitutionality of individual mandates and other discrete provisions of the legislation, it is inevitable that the federal courts will be called upon to assist in validating and refining the regulatory scheme that will unfold over the next several years. We are reminded, once again, that it is "emphatically the province of the courts to say what the law is," and there is no doubt that federal courts, the bench and the bar, will have an essential and ultimate role in defining health care reform. **TFL**

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Endnotes

[1]President Barack Obama signed the legislation into law on March 23, 2010; Virginia and Florida filed suit that same day.

[2]Suit was filed in Michigan on April 6, 2010, *Thomas More Law Center et al. v. Barack Hussein Obama et al.* Case No. 2:10-cv-11156-GCS-RSW.

[3]Case No. 08-1515.

[4]Health Care Security Ordinance 10-0 (File No. 051919, Ordinance 218-06), signed into law Aug. 4, 2006, at S.F. Cal. Admin. Code § 14.1–14.8.

[5]S.F. Cal. Admin. Code § 14.2(e).

[6]The current rate is either $1.23 or $1.85 per hour, depending on certain employer characteristics.

[7]ERISA, 29 U.S.C. § 1144(a).

[8]*Golden Gate Rest. Ass'n v. City & County of San Francisco*, 535 F. Supp. 2d 968, 979–980 (N.D. Cal. 2007).

[9]512 F.3d 1112, 1114 (9th Cir. 2008).

[10]ERISA pre-emption questions are reviewed de novo. *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1141 (9th Cir. 2003).

[11]Quoting *N.Y. State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645, 661 (1995).

[12]*Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir. 1992)(requiring "ongoing, particularized, administrative, discretionary analysis); *Valarde v. Pace Membership Warehouse Inc.*, 105 F.3d 1313, 1317 (requiring "*enough* ongoing, particularized, administrative, discretionary analysis to make the plan an ongoing administrative scheme.") (emphasis in original).

[13]But for her nomination to the U.S. Supreme Court, it is likely that the brief would have been submitted by Justice Elena Kagan. The brief was filed on May 28, 2010, Elena Kagan's nomination was announced on May 10, 2010.

[14]Section 5000A(c)(3).

[15]Civil Action 3:10CV188.

[16]*Id.* at 6.

[17]Virginia Code, § 38.2-3430.1:1 (2010).

[18]Citing *Massachusetts v. Mellon,* 262 U.S. 447 at 485–86 (1923).

[19]*Id.* at 5.

[20]*Id.* at 5–6, quoting *Gonzales v. Raich,* 545 U.S. 1, 39 (2005)(Scalia, concurring in the judgment).

[21]*Gonzales* at 17.

[22]Memorandum Opinion at 19.

[23]Memorandum Opinion at 21.

[24]130 S. Ct. at 1956–57 (2010).

[25]Memorandum Opinion at 23.

[26]Memorandum Opinion at 26.

[27]TR. 81:18–21, July 1, 2010, citing *Bailey v. Drexel Furniture Co.*, 259 U.S. 20, 37 (1922).

[28]Memorandum Opinion at 31, citing TR. 21:10–11, July 1, 2010.

[29]*Thomas More Law Center et al., v. Barack Hussein Obama et al.,* Case No. 2:10-cv-11156-GCS-RSW, April 6, 2010.

[30]*Thomas More*, Brief at 17.

[31]Complaint at 6–7.

[32]Quoting *Alaska Airlines Inc. v. Brock*, 460 U.S. 678, 684 (1987).