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No. 11-398

In the Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,
Petitioners,

v.

STATE OF FLORIDA, *et al.*,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

BRIEF OF THE STATES OF MARYLAND, CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, NEW MEXICO, NEW YORK, OREGON, AND VERMONT, THE DISTRICT OF COLUMBIA, AND THE VIRGIN ISLANDS AS AMICI CURIAE IN SUPPORT OF PETITIONERS

(Addressing Minimum-Coverage Provision)

DOUGLAS F. GANSLER
Attorney General of Maryland

JOHN B. HOWARD, JR.
Deputy Attorney General

WILLIAM F. BROCKMAN
Acting Solicitor General
Counsel of Record

JOSHUA N. AUERBACH
STEPHEN M. RUCKMAN
SARAH W. RICE
Assistant Attorneys General
200 Saint Paul Place
Baltimore, Maryland 21202
wbrockman@oag.state.md.us
(410) 576-7055

Attorneys for Amici Curiae

(Additional Counsel Listed on Inside Cover)

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

KAMALA D. HARRIS
Attorney General of California
1300 I Street
Sacramento, California 95814

GEORGE JEPSEN
Attorney General of
Connecticut
55 Elm Street
Hartford, Connecticut 06106

JOSEPH R. BIDEN, III
Attorney General of Delaware
820 N. French Street
Wilmington, Delaware 19801

DAVID M. LOUIE
Attorney General of Hawaii
425 Queen Street
Honolulu, Hawaii 96813

LISA MADIGAN
Attorney General of Illinois
100 West Randolph Street,
12th Floor
Chicago, Illinois 60601

TOM MILLER
Attorney General of Iowa
1305 East Walnut Street
Des Moines, Iowa 50319

GARY KING
Attorney General of
New Mexico
P.O. Drawer 1508
Sante Fe, New Mexico 87504

ERIC T. SCHNEIDERMAN
Attorney General of New York
120 Broadway, 25th Floor
New York, New York 10271

JOHN R. KROGER
Attorney General of Oregon
1162 Court Street NE
Salem, Oregon 97301

WILLIAM H. SORRELL
Attorney General of Vermont
109 State Street
Montpelier, Vermont 05609

IRVIN B. NATHAN
Attorney General for the
District of Columbia
441 4th Street, N.W., Suite
600 South
Washington, D.C. 20001

VINCENT F. FRAZER
Attorney General of the Virgin
Islands
Department of Justice
3438 Kronprindsens Gade
GERS Complex
St. Thomas, Virgin Islands 00802

QUESTION PRESENTED

Does Congress have the power, under Article I of the Constitution, to enact the minimum-coverage provision of the Patient Protection and Affordable Care Act, 26 U.S.C. § 5000A, which requires non-exempt individuals to maintain a minimum level of health insurance or pay a tax penalty?

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INTEREST OF AMICI STATES

Amici Curiae, the States of Maryland, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, New Mexico, New York, Oregon, and Vermont, the District of Columbia, and the Virgin Islands, have a strong interest in protecting and promoting the health, safety, and welfare of their citizens, an interest that the Affordable Care Act advances in vitally important ways.

The Amici States have each made determined efforts to address the extraordinary problems associated with the current system of healthcare delivery in the United States, including spiraling costs, limitations on the availability of insurance coverage, and restricted access to medical services. Although the Amici States have achieved modest successes, these state-by-state efforts cannot fully counteract the force of inexorable national trends driven by problems that are fundamentally interstate in nature. The experience of the Amici States demonstrates the need for action on the national level.

The Amici States also bring a unique perspective to the questions of federalism raised in this case. The Amici States, no less than the Respondent States, embrace our system of dual sovereignty and resist federal encroachment in areas properly reserved to the states. Still, principles of federalism must not be misapplied to block federal legislation that addresses truly national problems, leaving both states and the federal government unable to adequately address and resolve pressing national

concerns. The Amici States also have a compelling interest in ensuring that constitutional principles of cooperative federalism are validated when Congress seeks to address important national problems by enacting legislation that will be implemented through the joint participation of the federal government and the states, as Congress has done here.

INTRODUCTION

Though the respondents' challenge to the Affordable Care Act's minimum-coverage provision is rooted in supposed limits on federal power inherent in the Commerce Clause, their claim has little to do with the core concerns that have animated this Court's Commerce Clause jurisprudence: it does not raise "our oldest question of constitutional law[,] . . . discerning the proper division of authority between the Federal Government and the States," *New York v. United States*, 505 U.S. 144, 149 (1992), nor does it implicate the problem of drawing "distinction[s] between what is truly national and what is truly local," *United States v. Morrison*, 529 U.S. 598, 617 (2000).

There can be no serious contention that existing defects in the country's markets for health care and health insurance—markets that accounted for 17.6% of the entire national economy in 2009—are somehow local in origin, in scope, or in effect. Nor can one seriously contend that requiring most Americans to obtain a minimum level of health

insurance coverage—through their employers, through a state health benefit exchange, or through a state Medicaid program—unduly encroaches on state authority or state prerogatives.

As a result of the systemic problems in our healthcare system, a large and growing number of Americans—49 million in 2009—lack health insurance and reliable access to basic healthcare services; employers increasingly find it effectively impossible to provide healthcare benefits to their employees; and healthcare costs claim a massive and steadily expanding proportion of the budgets of American families, of state and federal expenditures, and of the national economy as a whole. Emergency rooms now double as primary-care clinics for millions of uninsured; hundreds of thousands of Americans have been driven into personal bankruptcy because of their inability to pay for health care; and state governments, in each budget cycle over the last generation, have had to grapple with increasingly painful choices about whether, and if so how, to pay for health care for their most vulnerable citizens.

The crisis in our healthcare system "is plainly national in area and dimensions"—much like the problem of elderly poverty that Congress comprehensively addressed in enacting the Social Security Act, *Helvering v. Davis*, 301 U.S. 619, 644 (1937). Though state governments and private actors have taken important and innovative steps to expand access to health care and to restrain the growth of health care costs, no remedy can be fully effective without action on a national level. The Commerce Clause empowers Congress to take such

action, and Congress properly employed that power in addressing the nation's healthcare crisis through the reforms enacted in the Affordable Care Act.

In enacting the Affordable Care Act, Congress chose not to establish a single-payer system or a national service for healthcare delivery. Instead, the reforms selected by Congress leave essentially undisturbed the predominantly private, market-based character of our healthcare economy. Just as importantly, Congress designed its reforms in a manner that respects the existing balance of responsibility between the federal government and the states. The Act does not displace state regulatory authority, but instead proceeds on the basis of cooperative federalism: two of the three principal channels through which the Act expands access to health insurance—Medicaid programs and health benefit exchanges—are intended to be established, developed, and operated by the states according to their own policy choices.

SUMMARY OF ARGUMENT

Rather than embrace the essential genius of the constitutional design and its allocation of regulatory authority between the states and the national government, the respondents seek to justify their attack on the minimum-coverage provision with a novel misconception of the commerce power, one that does not derive from any principled understanding of federalism. The Constitution restricts Congress's power to regulate commerce by limiting its object to interstate commerce: "Commerce . . . among the

several States." The Constitution imposes this limitation—not as an adjunct to the individual rights enshrined elsewhere in the Constitution—but as a protection against incursions on the regulatory authority of the states. The restrictions on Congress's commerce power thus reinforce our federalist system of dual sovereignty.

But the conception of the commerce power that underlies the respondents' attack on the minimum-coverage provision does not derive from any principled understanding of federalism. On the contrary, the respondents' theory reflects a misapprehension of this Court's teachings about the nature of the federal commerce power. It is not true, as the respondents appear to believe, that the Constitution "presupposes a lack of plenary federal authority" to regulate interstate commerce. State Respondents' Cert.-Stage Brief at 1. This Court has repeatedly affirmed that, within the domain of interstate commerce, Congress's authority is indeed "plenary," and does not differ in its reach from the authority that states possess with respect to intrastate commerce.

Moreover, despite the rhetoric that accompanies the challenge to the minimum-coverage provision, the constitutional limitations on the commerce power do not embrace a libertarian objection to Congress's exercise of regulatory authority over the conduct of individuals. Rather than marking a "departure from commerce power norms," Pet. App. 112a, the exercise of federal authority to regulate individual conduct is consistent with the design of the Framers, who "opted for a Constitution in which Congress would exercise its legislative authority

directly over individuals. . . ." *New York,* 505 U.S. at 165.

In invoking federalism limitations as the basis for their challenge to the Affordable Care Act, the respondents fail to appreciate that the federal commerce power exists precisely to allow Congress to address problems—like those that plague the nation's healthcare system—that do not respect state boundaries and that the states cannot fully and effectively address on their own.

The factual premise for the respondents' challenge to the minimum-coverage provision—based on an ostensible distinction between activity and inactivity—ignores reality by supposing that there are a meaningful number of citizens who will never obtain health care and who therefore will never affect the country's healthcare economy. To the contrary, as the D.C. Circuit recognized, the health insurance market is unique, "both because virtually everyone will enter or affect it, and because the uninsured inflict a disproportionate harm on the rest of the market as a result of their later consumption of health care services." *Seven-Sky v. Holder*, 661 F.3d 1, 18 (D.C. Cir. 2011). Congress acted within its authority in taking account of these unique features of the healthcare economy and in enacting the minimum-coverage provision, without which the Affordable Care Act's other vital reforms would not be fully effective.

The Affordable Care Act does not represent an incursion on state sovereignty. Rather, it is an indispensable aid to the states in their own efforts to tackle the healthcare problems their citizens face.

The framework established by the Affordable Care Act empowers the states, in partnership with the federal government, to create enduring solutions to the nation's healthcare crisis. Where, as here, Congress has exercised its commerce power to act in partnership with the states to confront problems with both interstate and intrastate dimensions, Congress honors, rather than transgresses, the structural limitations embodied in the Constitution.

♦

ARGUMENT

I. THE HEALTHCARE REFORMS CONGRESS ADOPTED IN THE AFFORDABLE CARE ACT FALL SQUARELY WITHIN THE HISTORICAL UNDERSTANDING OF THE COMMERCE POWER AS A TOOL FOR ADDRESSING INTERSTATE PROBLEMS THAT STATES CANNOT EFFECTIVELY ADDRESS ALONE.

The Commerce Clause represents "the Framers' response to the central problem giving rise to the Constitution itself: the absence of any federal commerce power under the Articles of Confederation." *Gonzalez v. Raich*, 545 U.S. 1, 16 (2005). That absence of federal authority resulted not only in a national government effectively incapable of making national policy on matters of interstate and international commerce, but in the frustration of *state* efforts to make policy on the same matters. As the Court explained in *New York v. United States*, the Framers adopted the Commerce Clause to address this "central problem" by conferring plenary power on the federal government

to regulate interstate commerce. 505 U.S. at 163-66. This power by definition included the authority to regulate directly the conduct of individual citizens. *See id.* at 165 (the Framers "opted for a Constitution in which Congress would exercise its legislative authority directly over individuals").

The crisis in our country's healthcare system is a contemporary example of the type of intractable interstate problem for which the Framers adopted the Commerce Clause. It is a problem with national scope and one that the states, acting alone, cannot fully address. The remedy that Congress selected to address the problem, the Affordable Care Act, falls well within the power that the Commerce Clause confers.

A. The Commerce Clause Enables Congress to Regulate Interstate Commerce Comprehensively.

1. The Framers Empowered Congress to Act to Address Problems of National Scope.

The Commerce Clause's grant of broad power to Congress to "regulate Commerce . . . among the several States" reflected lessons learned from the failure of the Articles of Confederation. Under Article IX of the Articles of Confederation, the states themselves regulated commerce. Without a mechanism for the federal government to coordinate and facilitate interstate commerce, the states were hindered in their ability to confront problems with interstate dimensions. As James Madison observed,

a major "defect" in this arrangement was its inability to facilitate action in "concert in matters where common interest requires it," particularly with regard to "our commercial affairs." James Madison, *Vices of the Political System of the United States*, in 9 The Papers of Madison 348 50 (Robert A. Rutland *et al*., eds., 1975). Without coordinated interstate action, a patchwork of state laws "restrict[ed] the commercial intercourse with other States"; this arrangement frustrated economic development and was "destructive of the general harmony." *Id.*

Alexander Hamilton adhered to the same view. He observed profound economic insecurity under the Articles of Confederation: "commerce . . . at the lowest point of declension," "a violent and unnatural decrease in the value of land," and the drying up of "private credit," with "borrowing and lending . . . reduced within the narrowest limits." Federalist No. 15. For Hamilton, this economic insecurity could "only be fully explained by that want of private and public confidence" in the efficacy of the national government. *Id.* Collective action problems, Hamilton further observed, hindered the states from effectively addressing these problems:

> The greater deficiencies of some States furnished the pretext of example and the temptation of interest to the complying, or at least to the delinquent States. Why should we do more in proportion than those who are embarked with us on the same political voyage? Why should we consent to bear more than our proper share of the common burden?

Id.

This structural defect led Madison and his fellow Framers to advocate for a new Constitution under which the national government would have the power to "[m]aintain[] . . . harmony and proper intercourse among the States." The Federalist No. 41 (J. Madison) (Clinton Rossiter ed., 1961).[1] Under their proposal, Congress would have the power "to legislate in all cases to which the separate States are incompetent, or in which the harmony of the United States may be interrupted by the exercise of individual Legislation." Though some contemporaries advocated stronger limitations on Congress's powers, the committee of the Constitutional Convention that drafted Article I, Section 8 adopted the approach that Madison and the Virginia delegation had proposed.

The powers enumerated in Article I, Section 8—including the power to "regulate Commerce . . . among the several States"—overcame shortcomings in the previous system by enabling the federal government to address problems that the states could not effectively resolve through uncoordinated, state-by-state action. *See Gonzales v. Raich*, 545 U.S. 1, 16 (2005) ("The Commerce Clause emerged as the Framers' response to the central problem giving

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[1] *See also* Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 Stan. L. Rev. 115, 121 (2010) ("The structure of governance established by the Articles of Confederation often prevented the states from acting collectively to pursue their common interests. Solving these problems of collective action was a central reason for calling the Constitutional Convention.").

rise to the Constitution itself: the absence of any federal commerce power under the Articles of Confederation."); *see also Oregon Waste Sys., Inc. v. Department of Envtl. Quality*, 511 U.S. 93, 98-99 (1994) ("The Framers granted Congress plenary authority over interstate commerce in 'the conviction that in order to succeed, the new Union would have to avoid the tendencies toward economic Balkanization that had plagued relations among the Colonies and later among the States under the Articles of Confederation.'" (quoting *Hughes v. Oklahoma*, 441 U.S. 322, 325–26 (1979))).

2. Congress Has the Power to Regulate Individual Conduct that Substantially Affects Interstate Commerce.

The federal commerce power, by deliberate design, includes the power to regulate individual conduct. This Court has repeatedly recognized that the grant of federal power under the Commerce Clause is "plenary" in nature. *See*, *e.g*., *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276 ("[T]he Commerce Clause is a grant of plenary authority to Congress."); *United States v. Darby*, 312 U.S. 100, 114 (1941); *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 197 (1824) ("[T]he sovereignty of Congress, though limited to specified objects, is plenary as to those objects."). This plenary power necessarily includes the power to regulate individual conduct. As the Court explained in *New York v. United States*, "[u]nder the Articles of Confederation, Congress lacked the authority in most respects to govern the people directly. . . . The inadequacy of this governmental structure was responsible in part

for the Constitutional Convention." 505 U.S. at 163. Through the Commerce Clause and other counterpart provisions, the Framers determined to "'extend the authority of the Union to the persons of the citizens—the only proper objects of government.'" *Id*. (quoting Federalist No. 15). The Framers deliberately established a federal government able to "'carry its agency to *the persons of the citizens*,'" a "'government of the Union, like that of each State, . . able to address itself immediately to the hopes and fears of individuals.'" *Id*. (quoting Federalist No. 16) (emphasis added).

The Commerce Clause empowers Congress to regulate the conduct of individuals whose actions substantially affect interstate commerce. Indeed, as the Court's cases establish, Congress may regulate under the Commerce Clause the conduct of individual people whose decisions *not* to participate in interstate commerce nonetheless have a substantial effect on interstate commerce. It so concluded with respect to federal restrictions on the cultivation of wheat for home consumption in *Wickard v. Filburn*, and, more recently, with respect to federal proscription of the cultivation of marijuana for home consumption in *Gonzalez v. Raich*. As the Court explained in the latter case, "the regulation is squarely within Congress's commerce power because production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." 545 U.S. at 19 (discussing *Wickard v. Filburn*, 317 U.S. 111 (1942)).

In this regard, "[t]he authority of the federal government over interstate commerce does not differ in extent or nature from that retained by the states over intrastate commerce." *Darby*, 312 U.S. at 116. Just as states have plenary authority to regulate commerce within their boundaries, *see Danforth v. Minnesota*, 552 U.S. 264, 280 (2008), so too does Congress have plenary authority to regulate commerce that crosses state boundaries.

B. Longstanding Precedent Confirms the Understanding of the Commerce Power as a Means of Enabling Congress to Address Problems that Require Coordination and Cooperation Among the States.

From the time of Chief Justice Marshall, this Court has consistently interpreted Congress's commerce power as one intended to address problems that require coordination among states, where states, acting alone, can create problems affecting other states. In the seminal case of *Gibbons v. Ogden*, the Court recognized that the commerce power was necessary to prevent one state from stifling the development of both another state's commerce and interstate commerce in the United States generally. Commerce "among" the states, the Court explained, meant commerce of one state "intermingled" with that of others, which necessarily "cannot stop at the external boundary of each State." 22 U.S. at 194. Without federal power to coordinate this intermingled commerce, actions by one state could negatively affect commerce in another state or among states. Therefore, the Court held, the

Commerce Clause must be understood as granting Congress the power to regulate "that commerce which concerns more states than one." *Id.*

As the nation's economy evolved and became more interdependent, the Supreme Court recognized that even small intrastate transactions could affect interstate commerce. In *Wickard v. Filburn*, the Court upheld the application of federal price-stabilization laws to a single farmer's production of wheat for home consumption, finding that the effect of his contribution to the wheat market, when "taken together with that of many others similarly situated, is far from trivial." 317 U.S. at 128. The Court held that the commerce power "extends to those activities intrastate which so affect interstate commerce . . . as to make regulation of them appropriate means to the attainment of a legitimate end, the effective execution of the granted power to regulate interstate commerce." 317 U.S. at 124 (citation omitted).

The Court has also recognized that a single state can put itself at a competitive disadvantage with other states if it expends resources to address a general societal ill while other states fail to take action. In *Darby*, the Court held that federal wage-and-hour regulations were necessary to prevent unfair competition between businesses in states with such laws and those in states without them, and that such nationwide regulations were within Congress's commerce power. *See* 312 U.S. at 115. A state-by-state approach to eradicating "the evils . . . of substandard labor conditions" would result in the "dislocation of the commerce itself caused by the impairment or destruction of local businesses" seeking to compete in a system of interstate

commerce. *Id.* at 122. Only Congress, exercising its commerce power, can legislate a solution while maintaining a level playing field among the states.

Thus, longstanding precedent has established that the federal commerce power supplies the basis for coordinated action to resolve problems that states, acting within their borders, cannot effectively address alone. As the Court explained in *United States v. South-Eastern Underwriters Association*, the federal commerce power encompasses "the power to legislate concerning . . . transactions which, reaching across state boundaries, affect the people of more states than one—to govern affairs which the individual states, with their limited territorial jurisdictions, are not fully capable of governing." 322 U.S. 533, 552 (1944). The nation's healthcare crisis is one that states are "not fully capable of governing" without federal regulation that addresses the interstate dimensions of the healthcare economy.

C. Our Nation's Healthcare Crisis Is an Interstate Problem that States Cannot Fully Address on Their Own, and Is Thus a Proper Subject for the Exercise of Congress's Commerce Power.

1. The Problem of Uncompensated Care Transcends State Boundaries.

The interstate nature of the market for health care is beyond serious dispute. The healthcare economy accounted for 17.6% of the nation's gross domestic product in 2009. Many hospital corporations operate in numerous states, and

medical supplies, drugs, and equipment—not to mention patients—routinely cross state lines. *See* 42 U.S.C. § 18091(a)(2)(B). Spending for health insurance exceeded $850 billion in 2009, and the majority of health insurance is sold by national or regional companies. *See id*. The value of healthcare services provided to those without insurance in 2008 was $116 billion. *See* Families USA, *Hidden Health Tax: Americans Pay a Premium* 2 (2009). Congress found that providers were not compensated for $43 billion of that total; that providers shift a substantial portion of those costs onto insurance companies and other payers; and that annual family health insurance premiums are, on average, more than $1,000 higher than they otherwise would be as a result of the further shifting of those costs. *See* 42 U.S.C. § 18091(a)(2)(F).

No state has fully insulated itself from the alarming trends in the number of people who lack insurance and in the overall cost of health care. In 2009, for example, 21.9% of Californians, 10.7% of Hawaiians, 11.8% of Iowans, 16.1% of Marylanders, 16.1% of New Yorkers, and 21.8% of Oregonians lacked health insurance; in the absence of the reforms Congress adopted in the Affordable Care Act, those figures were projected to rise by 2019 to 25.6%, 12.4%, 13.5%, 18.9%, 18.5%, and 26.1% respectively. *See* Bowen Garrett, *et al*., *The Cost of Failure to Enact Health Reform* (2009), *available at* http://www.rwjf.org/files/research/49148.pdf.

The American Hospital Association estimates that the value of hospital-based uncompensated care has risen steadily over the last 30 years, from $3.9 billion in 1980 to $39.1 billion in 2009. *See*

American Hospital Association, *Uncompensated Hospital Care Fact Sheet* (Dec. 2010), *available at* http://www.aha.org/content/00-10/10uncompensated care.pdf. Total national healthcare expenditures have risen from $27.3 billion in 1960, or 5.2% of the gross domestic product in that year, to $2.5 trillion, or 17.6% of the gross domestic product, in 2009. Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data Web Tables T.1 (2011), *available at* https://www.cms.gov/National HealthExpendData/downloads/tables.pdf. In enacting the Affordable Care Act, Congress projected that, without meaningful reform, total national health expenditures would rise to $4.7 trillion in 2019. *See* 42 U.S.C. § 18091(a)(2)(B).

In Maryland, where hospitals in 2009 provided $999 million in uncompensated care to the uninsured,[2] the State has established a healthcare compensation structure to regulate and rationalize the economic consequences of the "inactivity" that is the core subject of this case. As a result of this system, it is possible to trace more concretely the substantial effect on the healthcare economy of failing to maintain adequate health insurance. Under Maryland's all-payer system, for which it has received a waiver from the federal government under 42 U.S.C. § 1395f(b), the State's Health Services Cost Review Commission sets the rates for hospital in-patient services paid by all payers, including private insurers, the federal Medicare program, and

[2] *See* Health Services Cost Review Commission 2010 Report, at 2-4, *available at* http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/AnnualReports/GovReport10_MD_HSCRC.pdf.

the State's Medicaid program. *See* Md. Code Ann., Health-Gen. §§ 19-211, 19-212. In establishing the Commission, the Maryland General Assembly expressly sought to address the market problems associated with uncompensated care, *see* Md. Code Ann., Health-Gen. § 19-214, and a key virtue of the all-payer rate-setting system is that it rationalizes the shifting of the costs of uncompensated care, avoiding a situation in which the bargaining power of each payer determines the extent to which the costs of uncompensated care will be shifted to it. Each year, after studying the level of uncompensated care, the Commission authorizes hospitals to impose a surcharge to reimburse them for costs associated with providing uncompensated care. In 2009, that surcharge was 6.91%. *See* 2009 Budget Analysis, Health Regulatory Commissions, Department of Health and Mental Hygiene, at 18, *available at* http://mlis.state.md.us/2009rs/budget_docs/all/operating/m00r_dhmh_health_regulatory_commissions.pdf. Thus, in Maryland, the "inactivity" that is the subject of this case—failing to maintain adequate health insurance—inflated the cost of in-patient hospital care to those who did maintain health insurance by nearly 7%.

2. Decisions to Forego Insurance Have a Substantial Effect on Interstate Commerce.

In the healthcare context, the respondents' proffered distinction between "activity" and "inactivity" utterly fails to generate principled rules for the exercise of regulatory authority. The proper allocation of constitutional authority does not turn on the "activity" or "inactivity" of healthcare

consumers, as the respondents contend, and this Court has refused to draw such artificial lines when reviewing Congress's exercise of the commerce power. *See Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 547 (6th Cir. 2011) (Martin, J.) ("[T]he text of the Commerce Clause does not acknowledge a constitutional distinction between activity and inactivity, and neither does the Supreme Court."); *id.* at 560 (Sutton, J., concurring) (Commerce Clause does not "contain an action/inaction dichotomy that limits congressional power"); *Seven-Sky*, 661 F.3d at 16 ("No Supreme Court case has ever held or implied that Congress's Commerce Clause authority is limited to individuals who are presently engaging in an activity involving, or substantially affecting, interstate commerce."); *see also Carter v see also Carter v. Carter Coal Co.*, 298 U.S. 238, 307-08 (1936) (Commerce Clause permits regulation of any "activity *or condition*" that substantially affects interstate commerce (emphasis added)).

The irrelevance of the supposed distinction between "activity" and "inactivity" is evidenced in *Wickard*, where the Court found that a decision to "forestall resort to the market" for wheat—like a decision to forestall resort to the health insurance market—could, in the aggregate, substantially affect a national market. 317 U.S. at 127-28. Similarly, in *Raich*, the Court found that growing or possessing marijuana for one's own use—without any consumption, trade, or other "activity" related to it—is subject to federal regulation, where Congress had a rational basis for believing that, when viewed in the aggregate, that conduct would affect price and market conditions. *See* 545 U.S. at 19; *see also Seven-Sky v. Holder*, 661 F.3d 1, 16-18 (D.C. Cir.

2011). So too with health care: there is little dispute that the uninsured will impose billions of dollars in costs on the national economy regardless of whether their lack of insurance is deemed "activity" or "inactivity."

In any event, forgoing health insurance is indeed an activity. As Judge Sutton has explained, "No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk. Each requires affirmative choices; one is no less active than the other; and both affect commerce." *Thomas More,* 651 F.3d at 561 (Sutton, J., concurring). "[F]ar from regulating inactivity, the minimum coverage provision regulates individuals who are, in the aggregate, active in the health care market." *Id*. at 548 (Martin, J.). If it is "inactivity" to forgo health insurance, when the United States expends more than $43 billion annually to cover the cost of care for those without insurance, then there's a whole lot of "inactivity" going on in the national healthcare market.

3. State-Level Reforms Cannot Fully Address the Problems Associated With Uncompensated Care.

Uncompensated care in one state creates effects for multiple states, and so represents a problem that is not fully susceptible to state-by-state solutions. The impediments are practical ones and are rooted in the interconnectedness of the American economy. Today, if a state adopts a policy to reverse the rising number of people lacking access to basic health care, or to control the spiraling costs of health care,

insurers who object to that policy can exit that state with relative ease, as could healthcare providers, individuals, and employers who wish to avoid the taxes, insurance expenses, or other burdens associated with the state's policy. At the same time, individuals and employers may easily enter a state if they wish to avail themselves of better healthcare policies, such as a state-imposed "guaranteed-issue" requirement that ensures the availability of coverage regardless of pre-existing conditions. Similarly, a state's decision to adopt more expansive standards for Medicaid eligibility may attract applicants from states that retain stricter standards. Conversely, relocating to another state may present an attractive alternative for individuals and employers who wish to avoid taxes, insurance expenses, or other burdens associated with the policies adopted in their home state.

There are, of course, numerous examples of effective state policymaking in the area of health care, many of which Congress drew upon in enacting the Affordable Care Act. Washington State's insurance program for people who have modest incomes but who are ineligible for Medicaid, for instance, served as the model for the option in the Act for states to create a "basic health program." 42 U.S.C. § 18091. And, most notably, Massachusetts, which enacted a set of minimum-coverage, guaranteed-issue, and community-rating requirements similar to those contained in the Act, has succeeded in reducing the percentage of its citizens lacking health insurance to 4.4%—by far the lowest in the country. *See* U.S. Census Bureau, Health Insurance, Health Insurance Historical Tables,

available at http://www.census.gov/hhes/www/hlthins/data/historical.

Nonetheless, experience shows that, in the health insurance field, as in the fields of unemployment and old-age insurance, the interconnectedness of state economies imposes practical restrictions on the range of policy choices open to any individual state, and also limits the efficacy of any solution chosen by a state that departs substantially from policies adopted by other states. In the 1990s, a number of states attempted to address an increasing lack of access to individual insurance for sicker residents by enacting reform packages including "guaranteed issue" requirements. *See* Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. Health Politics, Policy & Law 175, 188 (2000).

Several of the states that attempted to institute these reforms saw insurance providers pick up stakes and cease participation in those states' insurance markets. In Kentucky, for example, 40 insurers departed the Commonwealth, leaving only two remaining providers to serve the statewide market, after the reforms were instituted in 1994; similarly, in Washington, all but one out-of-state commercial carrier stopped issuing new policies before the State's guaranteed-issue provision took effect. *See* Adele M. Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Politics, Policy & Law 152 (2000). In Washington, the one remaining commercial insurer experienced significant losses because sicker individuals flocked to its product. *See id.* at 140. When national carriers have the ability to avoid

exposure to such losses by simply ceasing to participate in reformed markets, states are forced to abandon wanted policies, as Kentucky and Washington ultimately did. *See id*. at 133, 136-37, 152, 158; Nancy C. Turnbull, *et al.*, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Short Case Studies of Six States* 7 (Feb. 2005); *see also* Pet. App. 230a-231a (Marcus, J., dissenting) (discussing experience of state-level healthcare reform that led to insurers exiting the market).

The experience of states attempting to go it alone reveals the serious risks of a purely state-by-state approach when neighbor states can offer a more congenial environment to insurance companies by forgoing healthcare reforms. This concern is particularly acute in states with few carriers in the market. In Alabama, for example, a single insurance carrier has a 96% share of the small-group market; in North Dakota, the corresponding figure is 91%.

Beyond the impediments to effective state policymaking that flow from the interconnectedness of each state's healthcare economy, many potential state solutions are foreclosed or preempted by federal law. As discussed below, federal regulation has displaced state authority to regulate large components of the healthcare sector. Self-funded employer health plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA"). Are largely beyond the reach of state regulators as a result of that statute's broad preemptive scope. In addition, the single largest source of healthcare expenditures, the Medicare program, is administered by the federal government without state

involvement. The states' regulatory authority is further limited by the Constitution itself, which prohibits a state from limiting its conferral of welfare benefits that are more generous than those provided by other states to people who lived in the State for the preceding year. *See*, *e.g.*, *Saenz v. Roe*, 526 U.S. 489 (1999). Thus, for example, any state that wishes to establish eligibility criteria for its Medicaid program substantially broader than those of its neighbors must be prepared, by virtue of constitutional mandate, to shoulder the cost of extending those benefits to any new arrivals who move to the state to avail themselves of Medicaid eligibility.

4. Federal Regulation Serves a Critical Role in Aiding State Healthcare Reform Efforts.

The states should, and undoubtedly will, play a critical role in health care reform; as discussed below, the Affordable Care Act fully embraces state policymaking within a national framework of cooperative federalism. In the absence of such a national framework, however, state policymaking is just as likely to be driven (or paralyzed) by interstate competitive pressures as by a desire to function as "laboratories of democracy" in finding innovative solutions to these extraordinarily pressing problems.

This Court long ago recognized—well before health insurance could be purchased over the internet—that the growing interconnection of state economies poses an ever-greater challenge to effective state-by-state policymaking on matters of national economic concern. Problems "plainly

national in area and dimensions" often require national solutions, as the Court recognized in 1937 in separate decisions upholding, respectively, the system of unemployment insurance benefits and the system of old-age benefits established in the Social Security Act. *See Steward Machine*, 301 U.S. 548, 586-89 (1937); *Helvering*, 301 U.S. at 644.

With respect to Congress's decision to provide a measure of income security to older Americans, Justice Cardozo explained for the Court that the "laws of the separate states cannot deal with [the problem of income insecurity and poverty among the elderly] effectively." *Helvering,* 301 U.S. at 644. This is so because, "[a]part from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors." *Id.* This fear is rational, and applies to single-state efforts to reduce the cost and improve the quality of healthcare services delivery, just as it applies to a "system of old age pensions," which, "if put in force in one state and rejected in another" creates "a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose." *Id.* For that reason, as this Court recognized, "[o]nly a power that is national can serve the interests of all" in reforming the interstate healthcare market. *Id*.

What is true of old-age pensions and healthcare reform was also true of the decision to establish a national system of federal-state cooperation for

providing unemployment insurance. There, too, as Justice Cardozo explained:

> [I]f states had been holding back before the passage of the federal law, inaction was not owing, for the most part, to the lack of sympathetic interest. Many held back through alarm lest, in laying such a toll upon their industries, they would place themselves in a position of economic disadvantage as compared with their neighbors or competitors. . . .

Steward Machine, 301 U.S. at 588.

The states have long been active, creative shapers of healthcare policy in this country. In the Affordable Care Act, Congress ensured that they will continue to function in that capacity in the future. For a host of practical and legal reasons, however, the states, acting alone, cannot fully address the defects in our country's healthcare system.

II. THE MINIMUM-COVERAGE PROVISION IS AN INTEGRAL ELEMENT OF CONGRESS'S INTERSTATE SOLUTION TO THE HEALTHCARE CRISIS.

The minimum-coverage provision is squarely within Congress's Commerce Clause powers. Exercising this power, Congress may regulate economic activities that, in the aggregate, have a substantial effect on interstate commerce. *See Gonzalez v. Raich*, 545 U.S. 1, 17 (2005). In addition, Congress may regulate noneconomic activity so long as the regulation is "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut

unless the intrastate activity were regulated." *United States v. Lopez*, 514 U.S. 549, 561 (1995). The minimum-coverage provision is a justifiable exercise of Congress's Commerce Clause authority because (1) the aggregate effect of maintaining a minimum level of insurance coverage has a substantial effect on commerce, and (2) the comprehensive solution to health insurance reform would be undercut without the minimum coverage provision.

The minimum-coverage provision is an essential and lawful part of the Affordable Care Act's attempt to provide healthcare access to individuals with preexisting conditions, a group that is among the hardest of the uninsured to cover. The provision is essential because it helps prevent individuals from free-riding on state and federal budgets and on those who responsibly obtain health insurance. It is also essential because, without it, the preexisting-condition prohibition would lead to much higher insurance premiums, causing more people to forgo health insurance, and thereby worsening the impact on state and federal budgets. This dynamic is borne out by the experience, discussed above, of states that saw higher premiums and reduced coverage following their adoption of guaranteed-issue requirements that were not accompanied by a requirement akin to that imposed by the minimum-coverage provision.

The increase in insurance premiums without a minimum-coverage requirement is due to the phenomenon of moral hazard: Under a system where health insurers cannot turn away people with preexisting conditions, many people will simply wait

to purchase insurance until they are facing a health emergency, secure in the knowledge that they will be able to obtain insurance for expensive treatments when the time comes. This manifestation of moral hazard, known as adverse selection, skews the insurance pool, since people will tend to opt into the pool only when they perceive their health risks to be great.

Two unique features of the healthcare market exacerbate the problem of adverse selection: the need for services is highly unpredictable, and the cost of those services can be ruinously expensive.[3] One's health condition, of course, is not static. There is no class of healthcare consumers who are forever impervious to illness and injury. Rather, presently healthy people ineluctably become unhealthy or injured in the future and then require more costly treatment, just as presently unhealthy people regain their health and then require less costly treatment. No insurance regime can survive if people can opt out when the risk insured against is only a risk, but opt in when the risk materializes. Congress enacted the minimum-coverage provision to prevent free riders from distorting market prices for insurance in this way.[4] The minimum-coverage provision is thus justified as "an essential part of a larger regulation"

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[3] Congress found that "62 percent of all personal bankruptcies are caused in part by medical expenses." 42 U.S.C. § 18091(a)(2)(G).

[4] *See* Niel S. Siegel, *Free Riding on Benevolence: Collective Action Federalism and the Individual Mandate*, 75 Law & Contemp. Probs. (2012), Working Paper at 25-27, *available at http://scholarship.law.duke.edu/faculty_scholarship/2386*.

of the health insurance industry. *Lopez*, 514 U.S. at 561.

III. THE AFFORDABLE CARE ACT, RATHER THAN DISPLACING STATE AUTHORITY, PRESERVES STATE POLICYMAKING DISCRETION IN THE IMPLEMENTATION OF HEALTHCARE REFORMS, BUILDING ON A SUCCESSFUL MODEL OF COOPERATIVE FEDERALISM.

A. The Affordable Care Act Builds on a Long Tradition of Federal-State Cooperation.

Today's healthcare economy is one in which there has already been substantial displacement of state regulatory authority. According to the U.S. Census Bureau, the federal Medicare program accounted for $502 billion in healthcare expenditures in 2009, representing—more than 20% of the national total. The Medicare program, unlike Medicaid, is administered exclusively by the federal government, without state involvement. Roughly half of the expenditures by private insurers are by self-funded employer health plans and largely beyond the reach of state regulatory authority by virtue of ERISA preemption. *See* 29 U.S.C. § 1144(a); *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1999).

In the Affordable Care Act, rather than further displacing state regulatory authority, Congress chose to proceed on the basis of "cooperative federalism," a manner of legislating in which Congress "allows the States, within limits

established by federal minimum standards, to enact and administer their own regulatory program, structured to meet their own particular needs." *Hodel*, 452 U.S. at 289. Although it is undisputed that Congress could have displaced state authority and enacted a single-payer system, its choice to rely on the private marketplace, state-operated Medicaid, and state-run insurance exchanges shows a profound respect for the principles of federalism that underlie Congress's enumerated powers.[5]

The Medicaid program, which in 2009 accounted for $374 billion in healthcare expenditures (or about 15% of the national total), is perhaps the preeminent example of this type of legislation. *See Wisconsin Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 495-96 (2002). States choose whether to participate in the Medicaid program, and its "cornerstone" is "financial contribution by both the Federal Government and the participating State." *Harris v. McRae*, 448 U.S. 297, 308 (1980). In the development of policy for the program, Congress leaves "a range of permissible choices to the States," and allows each State "to 'strike its own balance' in the implementation of the Act." *Blumer*, 534 U.S. at

[5] It is a notable irony of the respondents' challenge to the minimum-coverage provision, a challenge animated by libertarian values, that the most salient difference between, on the one hand, the Affordable Care Act's system for extending protection to those who today lack access to basic health care and, on the other hand, the insurance systems established in the Social Security Act and upheld against similar challenges in *Helvering* and *Steward Machine*, is that, in the Affordable Care Act, Congress relied principally on the private market, not on public insurance programs, to achieve its objectives.

495, 497 (internal citation omitted). Other examples of cooperative federalism include Aid to Families with Dependent Children, *King v. Smith*, 392 U.S. 309, 316 (1968); the Individuals with Disabilities in Education Act, *Schaffer v. Weast*, 546 U.S. 49, 52 (2005); the Clean Water Act, *Arkansas v. Oklahoma*, 503 U.S. 91, 101 (1992); and the Occupational Health and Safety Act of 1970, *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 97 (1992).

B. The Affordable Care Act Affords States Wide Latitude in Implementing Key Elements of the Act's Reforms.

The Affordable Care Act embraces the model of cooperative federalism. The millions of Americans who will gain access to affordable health insurance as a result of the Act's reforms will look primarily to one of three sources to obtain coverage: their employers, state Medicaid programs, and state health benefit exchanges. Currently-uninsured employees of large employers will gain access to employer-sponsored insurance by virtue of the Act's employer-responsibility provision. *See* 26 U.S.C. § 4980H. Many Americans will become newly eligible for Medicaid, which will be extended to cover those whose incomes do not exceed 133% of the federal poverty level. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Others who currently lack insurance may purchase it through a "health benefit exchange," a competitive insurance marketplace in each state. 42 U.S.C. § 18031. Congress has provided substantial federal funding for these exchanges, but has left to the states, in the first instance, the policy choices that determine how the

exchanges will be established and will operate. *See id*. Thus, of the three most significant channels through which previously-uninsured Americans will obtain insurance after full implementation of the ACA, one is the expansion of an existing private source of coverage (employer-sponsored insurance), and two are programs of cooperative federalism (state Medicaid programs and state-based health benefit exchanges).

With regard to the Act's expansion of Medicaid eligibility, it is sufficient for present purposes to emphasize what this Court has previously observed: the Medicaid program exemplifies "cooperative federalism," leaving "a range of permissible choices to the States" and allowing each State "to 'strike its own balance' in the implementation of the Act," *Blumer*, 534 U.S. at 495, 497. In expanding access to health care for the country's most vulnerable citizens, the Affordable Care Act does not create a giant new federal entitlement program. Instead, the Act expands a highly successful program that is jointly overseen by the federal government and the states and that is implemented entirely by the states.

With regard to health benefit exchanges, the Act provides in the first instance for the exchanges to be established and developed by the states themselves, subject to limited federal oversight and with the support of substantial federal funding. At least 13 states have enacted legislation concerning these exchanges, joining Massachusetts and Utah, both of which had previously established an exchange. The core functions of these state-based exchanges are (a) to certify "qualified health plans" for sale in the

state, (b) to facilitate the purchase of such plans by consumers seeking individual coverage, and (c) to assist small employers in enrolling their employees in such plans. 42 U.S.C. § 18031(b)(1), (d)(4)(A).

Significantly, a state has broad discretion to determine the basic package of benefits that a plan offered through its exchange must provide. *See* 42 U.S.C. § 18031(d)(3)(B). Moreover, under recent guidance from the Department of Health and Human Services, states have substantial latitude in defining "essential health benefits," based on conditions in each state's insurance market. *See* Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011. The minimum-coverage provision requires individuals to maintain insurance that provides these "essential health benefits." Thus, the operation of the very provision at issue in this case will be influenced by decisions made at the state level. And, naturally, the states may exercise this policymaking authority differently, arriving at results that are tailored to the needs and preferences of its citizens, thereby fulfilling one of the promises of our federal system by acting as laboratories for policy experimentation.

The Act further authorizes each state to make the fundamental determination whether its exchange will offer for purchase any plan that meets minimum requirements, or if instead its exchange will adopt so-called "active purchasing" approaches to certification, such as competitive bidding processes or negotiations with insurance carriers of plan terms, cost, network breadth, and service quality. *See* 42 U.S.C. § 18031(e)(1)(B); 76 Fed. Reg.

41,891-92, 41,921 (July 15, 2011). All of these provisions, as well as numerous others, afford to each state the opportunity to decide not only what kinds of health plans its exchange will offer for purchase, but—even more fundamentally—what kind of exchange it will have.

Beyond the fact that two of the three principal channels through which the Affordable Care Act expands access to health insurance are intended to be developed and implemented by the states themselves, the Act exemplifies cooperative federalism in other highly significant ways. For example, the Act affords each state the option, along with substantial federal financial assistance, to establish a "basic health program" for individuals who are ineligible for Medicaid but whose family income is less than 200% of the federal poverty level. *See* 42 U.S.C. § 18051. The Act also establishes a process, to be implemented jointly by federal regulators and state insurance commissioners, that will subject annual increases in health insurance premiums to enhanced regulatory rate review. *See* 42 U.S.C. § 300gg-94.

The Act also encourages policy innovation by the states, allowing states to apply for waivers of the Act's requirements, *see* 42 U.S.C. § 18052, and to test other "innovative payment and delivery models," 42 U.S.C. § 1315a. These provisions offer new opportunities for a state to shape the manner in which the federal *Medicare* program—again, accounting for roughly 20% of total national health expenditures—pays for care to beneficiaries in that state. *See* 42 U.S.C. § 1315a(b)(2)(B)(x) & (xi).

These core features of the Act, which bolster, rather than usurp, state authority in the arena of healthcare regulation, refute the respondents' contention, accepted by the panel majority below, that the Affordable Care Act "supersedes a multitude of the states' policy choices in key areas of traditional state concern" and "obliterat[es] the boundaries inherent in the system of enumerated congressional powers." Pet. App. 143a, 187a. In virtually every respect, Congress decided to maintain the existing balance of responsibility between the federal government and the states. Rather than supplant state authority, Congress directed federal regulators to work in cooperation with state Medicaid programs, state health benefit exchanges, state insurance commissioners, and other state institutions in such endeavors as expanding access to health care, regulating market participants, and testing innovative strategies to control healthcare costs. At a minimum, a comparison of the cooperative federalism that characterizes the approach taken in the Affordable Care Act with, for example, ERISA's preemption provision, through which Congress overrode all state authority to regulate roughly 15% of the entire healthcare economy, reveals the hyperbole in the respondents' claim that the Affordable Care Act "supersedes" state policy choices and "obliterates" our federalist system.

Moreover, in keeping with the best values of cooperative federalism, the states remain accountable to their citizens for the policy decisions they make in implementing essential aspects of healthcare reform, because the broad discretion afforded to state officials under the Act allow the

states to "structure[]" the reforms "to meet their own particular needs." *Hodel*, 452 U.S. at 289; *cf. Printz v. United States*, 521 U.S. 898, 929-30 (1997); *New York v. United States*, 505 U.S. at 167-68. In the critical provisions of the Act discussed above, Congress did not "consign States to the ministerial tasks of information gathering and making initial recommendations, while reserving to [the federal government] the authority to make final judgments under the guise of surveillance and oversight." *Alaska Dep't of Envtl. Conservation v. Environmental Prot. Agency*, 540 U.S. 461, 518 (2004) (Kennedy, J., dissenting). Rather, while addressing a crisis in the health care system that is plainly national in scope and effect, the Affordable Care Act "allow[s] state governments to be accountable to the democratic process," *id.*, in making and implementing critical state-level policy choices, such as in deciding the operating model for its health benefit exchange and in deciding what benefits must be provided in plans offered for purchase through the exchange.

The healthcare reforms adopted in the Affordable Care Act do not represent an incursion on state sovereignty or an encroachment on state regulatory authority. On the contrary, like the system of federal-state cooperation established in the Social Security Act for providing insurance against unemployment, the Act's "operation is not constraint, but the creation of a larger freedom, the states and the nation joining in cooperative endeavor to avert a common evil." *Steward Machine*, 301 U.S. at 587.

CONCLUSION

The judgment of the court of appeals invalidating the minimum-coverage provision should be reversed.

Respectfully submitted,

DOUGLAS F. GANSLER
Attorney General of Maryland

JOHN B. HOWARD, JR.
Deputy Attorney General

WILLIAM F. BROCKMAN
Acting Solicitor General
Counsel of Record

JOSHUA N. AUERBACH
STEPHEN M. RUCKMAN
SARAH W. RICE
Assistant Attorneys General
200 St. Paul Place, 20th Floor
Baltimore, Maryland 21202
wbrockman@oag.state.md.us
(410) 576-7055

Attorneys for Amici Curiae

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