No. 11-398

IN THE

Supreme Court of the United States

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 AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES, THE ARC OF THE UNITED STATES, BREAST CANCER ACTION, FAMILIES USA, FRIENDS OF CANCER RESEARCH, MARCH OF DIMES FOUNDATION, NATIONAL BREAST CANCER COALITION, NATIONAL COALITION FOR CANCER SURVIVORSHIP, NATIONAL HEALTH LAW PROGRAM, NATIONAL ORGANIZATION FOR RARE DISEASES, NATIONAL SENIOR CITIZENS LAW CENTER, NATIONAL WOMEN'S HEALTH NETWORK, THE OVARIAN CANCER NATIONAL ALLIANCE AND VOICES FOR AMERICA'S CHILDREN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

(MINIMUM COVERAGE PROVISION)

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INTERESTS OF AMICUS CURIAE[1]

Amici are leading organizations dedicated to helping those individuals facing insurance denials and rejections due to pre-existing conditions, including organizations dedicated to reducing the incidence of and the impact of major diseases, disorders, and disabilities, and engaged in advocacy on behalf of individuals affected with such conditions. *Amici* have amassed extensive knowledge of the impact of these conditions and of the history of remedies and policies aimed at lessening these impacts. *Amici* represent the interests of individuals who are at risk of serious financial and medical consequences if they cannot obtain insurance to cover the costs of their medical care. Such individuals are thus tangibly and profoundly harmed by health insurers' practice of denying coverage to persons with pre-existing medical conditions and other abuses that are prohibited by the insurance reforms in the ACA, to which the minimum coverage

[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, its members or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of *amicus* briefs and have filed letters reflecting their blanket consent with the Clerk.

provision is integral and essential.[2] Moreover, the barriers to affordable coverage eliminated by the ACA increase financial costs and compound medical threats for the entire population, since lack of access to affordable health insurance impedes timely diagnosis and treatment, postponing remedial action until remedies are both more expensive and less effective. Hence, *amici* have both a strong interest in preserving the insurance reforms in the ACA and the capacity to offer information that illuminates the soundness of Congress' conclusion that the minimum coverage provision is critical to the success of these vital reforms.

SUMMARY OF ARGUMENT

Empirical evidence and analysis demonstrate that Congress correctly concluded that a minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold."[3] Patient Protection and Affordable Care Act

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[2] "Minimum coverage provision" is the phrase employed in this brief for the statutory requirement to carry minimum levels of insurance or pay a penalty – what is sometimes referred to as the "individual mandate."

[3] "Guaranteed issue" refers to requirements that insurers accept specified applicants for coverage, e.g., small businesses applying for coverage. "Exclusion of coverage of pre-existing conditions" refers to the practice of denying coverage to persons who have or have had illnesses or conditions that could require treatment during the policy period. Kaiser Family Foundation,

("ACA"), Pub L. No. 111-148, 124 Stat. 119 § 1501(a)(2)(G) (2010). The evidence presented here – of which Congress was aware – shows that each of the seven states that enacted insurance reforms requiring insurers to cover individuals with pre-existing conditions and related reforms without also enacting a minimum coverage provision experienced disastrous results: steep, often unaffordable premium spikes and insurers exiting the market for individual insurance coverage altogether. By contrast, Massachusetts, the one state which enacted such reforms in conjunction with a minimum coverage provision, successfully achieved near-universal health insurance coverage while lowering health insurance premiums. Because the experience of these eight states demonstrates that the minimum coverage provision is "an essential part of a larger regulation of economic activity," it falls squarely within Congress' authority to regulate interstate commerce. *Gonzales v. Raich*, 545 U.S. 1, 24 (2005) (quoting *United States v. Lopez*, 514 U.S. 549, 561 (1995); U.S. Const. art. I, § 8).

The Eleventh Circuit majority, the only circuit to invalidate the provision, did so on the factually and legally indefensible argument that the minimum coverage provision is not tightly drafted enough to accomplish its admittedly valid objectives. This decision intrudes upon an area that is constitutionally reserved to the legislative branch,

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How Private Health Coverage Works: A Primer, 2008 Update (April 2008) ("How Private Health Coverage Works"), *available at* http://www.kff.org/insurance/upload/7766.pdf.

and it is thoroughly disproven by expert opinion and empirical evidence. Most notably, Massachusetts enacted a minimum coverage provision with similar exemptions and weaker penalties than the one contained in the ACA, and it succeeded in achieving near-universal insurance coverage while reducing premiums.

Working in conjunction with other critical components of the ACA, in particular its guaranteed issue provision and its ban on the exclusion of coverage due to pre-existing conditions, the minimum coverage provision will ensure that affordable health insurance and health care are available to people when they need it, reduce health care costs, prevent medical bankruptcies, encourage fluidity in the job market, and reduce the human and economic costs of preventable deaths.

In addition to its function as an essential means to ensuring universal insurance coverage without regard to pre-existing medical conditions or health status generally, Congress appropriately considered the minimum coverage provision necessary and essential to address the shifting of costs by uninsured individuals seeking medical care to other participants in the system – providers, the government (taxpayers), and insured individuals and families (through higher premiums). Individuals who do not carry insurance are nonetheless participants in the health care market and, collectively, shift billions of dollars of costs onto third parties. Cong. Budget Office, Key Issues in Analyzing Major Health Proposals 114 (2008),

available at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf. These adverse impacts are especially acute because Federal and state laws, as well as widespread practices and customs, require hospitals to provide treatment to uninsured individuals whether they can pay their bills or not. Correcting these widespread and severe market failures unique to the national health insurance and services sector provides ample justification for the minimum coverage provision.

In short, the overwhelming evidence from the experience of state health reform efforts and analyses of the health care market establishes far more than a rational basis for Congress's decision that the minimum coverage provision is essential to ensuring that the ACA ameliorates significant negative effects on the national economy.

ARGUMENT

"Where economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained." *Lopez*, 514 U.S. at 560. Additionally, when a provision of law is "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut" if the provision of law were struck down, *Raich*, 545 U.S. at 24 (quoting *Lopez*, 514 U.S. at 561), that provision falls within Congress' authority under the Commerce and Necessary and Proper Clauses. These two doctrines provide two independent reasons why the minimum coverage provision should be upheld. The minimum coverage provision regulates economic

activity within the health care and health insurance markets, and it is absolutely essential to the ACA's larger regulation of the insurance market. As this brief explains, this essential link between the minimum coverage provision and the ACA's insurance reforms is not only supported by congressional findings and expert research; it is also conclusively demonstrated by the experience of eight states that enacted insurance regulations similar to the ones contained in the ACA.

I. THE EXPERIENCE OF THE STATES DEMONSTRATES THAT ENSURING COVERAGE FOR PERSONS WITH PRE-EXISTING MEDICAL CONDITIONS HAS WORKED ONLY WITH A COMPLEMENTARY REQUIREMENT THAT PERSONS WHO CAN AFFORD IT CARRY HEALTH INSURANCE

The ACA's insurance regulations include what is commonly referred to as a "guaranteed issue" provision, which requires insurers to "accept every employer and individual . . . that applies for such coverage." 42 U.S.C. § 300gg-1(a). Additionally, a provision of the ACA known as its "modified community rating" provision places strict limits on an insurer's ability to charge higher premiums to higher risk consumers. § 300gg. A minimum coverage provision is an essential element of any law containing these reforms because of the problem of adverse selection.[4]

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[4] Hereinafter, these provisions are referred to collectively as the ACA's "pre-existing conditions" provisions.

Congress' judgment that the minimum coverage provision is integral to barring exclusions for pre-existing medical conditions and other insurance reforms was based on considerable evidence demonstrating that, without such a requirement, "many individuals will not choose to obtain coverage … [and] adverse selection will occur . . . ." Linda J. Blumberg & John Holahan, *Do Individual Mandates Matter?*, Urban Institute, Jan. 2008, *available at* http://www.urban.org/uploadedpdf/411603_individual_mandates.pdf. Adverse selection occurs when persons with a higher than average health risk disproportionately enroll in a given insurance plan. Currently healthy consumers will tend to delay the purchase of health insurance until they become ill or injured – forcing the insurer to pay them substantially more in benefits than they have previously paid in premiums, and increasing premiums for those who are insured. *See Fed. Ins. Co. v. Raytheon Co., 426* F.3d 491, 499 (1st Cir. 2005). Thus, this adverse selection is an economic activity that substantially affects interstate commerce because it leads to significantly higher premiums and other distortions of the health insurance market.

In hearings before Congress, a representative of the National Association of Insurance Commissioners testified that due to the "severe adverse selection" resulting from the "elimination of preexisting condition exclusions for individuals, State regulators can support these reforms to the extent they are coupled with an effective and

enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate Finance Committee*, 111th Cong. 3 (2009) (statement of Sandy Praeger, Chair of the Health Insurance and Managed Care Committee, Nat'l Ass'n of Insurance Comm'rs). Indeed, "[w]ithout the individual mandate, fundamental insurance-market reform is impossible[.]" Jonathan Gruber, *Getting the Facts Straight on Health Care Reform*, 361 New Eng. J. of Med. 2497, 2498 (2009), *available at* http://healthcarereform.nejm.org/?p=2473.

Moreover, Congress' judgment that a minimum coverage provision is essential to the ACA's insurance reforms is not merely supported by research and analysis. The need to couple insurance reform with a minimum coverage provision had been demonstrated by the actual experience of states which have tried to do otherwise and – without exception – failed.

A. State Bans On Excluding From Coverage People With Pre-Existing Conditions That Were Not Accompanied By A Minimum Coverage Provision Have Been Unsuccessful

Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington enacted legislation that required insurers to guarantee issue to all consumers in the individual

market,[5] but did not have a minimum coverage provision. *See* Ky. Rev. Stat. Ann. § 304.17A-060(2)(A) (West)(Kentucky, repealed); Me. Rev. Stat. Ann. Tit. 24-A. § 2736-C(3) (Maine); N.H. Rev. Stat. Ann. § 420-G:6 (1994)(New Hampshire); N.J. Stat. Ann. § 17B:27A-22 (West)(New Jersey); NY CLS Ins § 3231, 3232 (New York); Vt. Stat. Ann. tit. 8, § 4080B(d)(1)(Vermont); Wash. Rev. Code § 48.43.012(1)(Washington). All of these laws have had detrimental effects on the insurance markets in those states. All seven states suffered from sky-rocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers.

"The departure of nearly all insurers from Kentucky's individual market is probably the most widely known aspect of its reforms." Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Heath Politics, Pol'y & L. 133, 152 (2000) ("Riding the Bull"). By late 1996, only two providers were still selling new policies in Kentucky's individual market, and the most commonly cited reason given by the departing companies to explain their departure was Kentucky's pre-existing condition provisions. *Id.* at 152–53. Kentucky's reforms were eventually repealed in 1998. *See* 1998 Kentucky Laws Ch. 496 (H.B. 315).

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[5] "Individual market" refers to the market for health insurance policies for individuals not covered by employer-sponsored or other group health plans.

Maine experienced a similar loss of insurance providers from its individual market after its pre-existing condition provision was enacted in 1993. A 2001 report found that 13 of 18 major carriers ceased issuing new policies to individuals during the eight years after the provision became law. Maine Bureau of Insurance, *White Paper: Maine's Individual Health Insurance Market*, January 22, 2001, at 8 ("White Paper"). The report had equally grim news about costs. Many insurance providers doubled their premiums in just three years or less, and all but one of the state's HMOs experienced "at least one rate increase of 25% or more in 1998 or 1999." *Id.* at 6, 7 & 10.

The same Maine report cited New Hampshire as a cautionary tale of a state whose individual indemnity market completely collapsed. According to the report,

> New Hampshire was nearly left with no carriers in the market when Blue Cross Blue Shield of New Hampshire announced it was withdrawing from the individual market. The New Hampshire Insurance Department took emergency measures to preserve the market. Under the system adopted through emergency rulemaking, and later by statute, all group health insurance and excess loss carriers in New Hampshire are assessed an amount (36 cents monthly in 2000) per covered person. Funds are distributed to individual

> carriers according to a formula designed to compensate those with large losses.

Id. at 5. In 2003, New Hampshire amended its law to permit pre-existing conditions to be excluded for 9 months. Act of May 19, 1997, ch. 188, sec. 11, § 420-G:7, I(a) (2003).

After New Jersey's pre-existing conditions provision took effect in 1993, individual insurance market premiums skyrocketed. Between 1996 and 2001, the cost of the most generous individual insurance plans rose by more than 350 percent. Alan C. Monheit, et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23.4 Health Affairs 167, 169–70 (2004). Even HMO plans, which tend to resist premium increases, nearly doubled in price during this same timeframe. *Id.*

New York enacted pre-existing condition provisions for the individual market in 1993. Consequently, the portion of non-elderly New Yorkers without insurance worsened from 16.5 percent in 1992 to 20 percent in 1997; while during the same period of time the national average of Americans without coverage worsened from 17.8 percent to 18.4 percent. Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & L., 71, 76-77 (2000). A study of the New York individual market concludes that "[f]ollowing reform, the overall percentage of the population with insurance has worsened, and enrollment in the individual market has steadily diminished. Prices

have increased substantially more than in other portions of the market, due to adverse selection." *Id.* at 97.

Like New York, Vermont saw substantial increases in premiums after its similar insurance reform measures took effect in 1993. Mark A. Hall, *An Evaluation of Vermont's Reform Law*, 25 J. Health Politics, Pol'y & L. 101, 115 (2000).

Severe consequences resulted from Washington's law. Within just a few years, non-managed care options disappeared entirely from the individual market. Riding the Bull at 140; White Paper at 5. Among HMOs in the individual market, "[t]he trend since 1994 has been toward higher deductible and/or more managed products as insurers have progressively closed lower deductible, less tightly managed products." Riding the Bull at 140. The state's only insurer in the individual policy market stopped selling new individual policies. *Id.* By 2000, some Washington counties had no private individual coverage available at all. White Paper at 5. In 1999, the Washington state legislature modified its law to permit insurers to deny coverage to certain high-risk consumers.[6]

Recent experience with the early implementation of ACA indicates similar results in the national market when a pre-existing conditions

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[6] Some other aspects of Washington state's health reform have been successful. Carol M. Ostrom, *Washington 'a Step Ahead' of Health Law*, Seattle Times, Apr. 1, 2010, *available at* http://seattletimes.nwsource.com/html/localnews/2011504803_statehealthreform02m.html.

provision is not accompanied by a minimum coverage provision. In September 2010, several of the ACA's provisions protecting individuals with pre-existing conditions went into effect for children. Pub L. No. 111-148 § 10103(e). Immediately thereafter, several large insurance companies stopped offering new child-only insurance policies. A.C. Aizenman, *Major Health Insurers to Stop Offering New Child-Only Policies*, Washington Post (Sept. 20, 2010). A health insurance industry spokesperson explained that "[w]ith no … mandate currently in place, … the result over the next several years [until 2014, when the minimum coverage provisions takes effect] could be that the pool of children insured by child-only plans would rapidly skew toward those with expensive medical bills, either bankrupting the plans or forcing insurers to make up their losses by substantially increasing premiums for all customers." *Id.*

An unbroken pattern shows that pre-existing conditions provisions, absent a minimum coverage provision, are a failed experiment. At best, they result in premium increases. At worst, they cause the total collapse of a state's individual insurance market. Judge Marcus of the Eleventh Circuit summed up the evidence succinctly: "As the states that tried to effectuate guaranteed issue and community rating reforms without some form of individual mandate attest, trying to do the former without the latter simply does not work." *Florida v. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1349 (11th Cir. 2011), (Marcus, J., dissenting), *cert. granted*, 132 S. Ct. 603 (2011).

B. Massachusetts Successfully Banned Excluding From Insurance Plans Patients With Pre-existing Conditions By Requiring Minimum Coverage

In mid-2006, Massachusetts Governor Mitt Romney signed a health reform bill which included a minimum coverage provision. Mass. Gen. Laws ch. 111M, §§ 1-5. Massachusetts law already had a pre-existing conditions provision. Mass. Gen. Laws ch. 176M, § 3(a). The results were both striking and immediate. Although nationwide individual premiums increased an average of 14 percent over the next few years, "the average individual premium in [Massachusetts] fell from $8537 at the end of 2006 to $5143 in mid-2009, a *40% reduction while the rest of the nation was seeing a 14% increase*." Jonathan Gruber, Massachusetts Institute of Technology, The Senate Bill Lowers Non-Group Premiums: Updated for New CBO Estimates 1 (2009) (emphasis in original).

Indeed, by adding a minimum coverage provision to Massachusetts' existing insurance regulations, the 2006 law reversed a cycle of adverse selection that had already begun during the period when the state had a pre-existing conditions provision but no minimum coverage provision. Individuals who enrolled before the enactment of the minimum coverage provision were almost four years older, almost 50% more likely to be chronically ill and had health care costs about 45% higher than those who enrolled after the minimum coverage provision was fully effective. Amitabh Chandra,

Jonathan Gruber, and Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts*, The New England Journal of Medicine, January 27, 2011, p. 294, *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp101306. Thus, while a pre-existing conditions provision in Massachusetts increased enrollment of individuals with high health care costs and chronic illness, the enactment of the minimum coverage provision resulted in relatively healthy individuals also obtaining health insurance.

Congress was well aware of Massachusetts' experience when it crafted the ACA. In congressional findings explaining the need for the ACA's minimum coverage provision, Congress explicitly referenced Massachusetts' successful experience with a minimum coverage provision. 42 U.S.C. § 18091(a)(D); *see also Thomas More Law Center v. Obama*, 651 F.3d 529, 547 (6th Cir. 2011) (explaining that Congress decided to emulate Massachusetts' successful minimum coverage provision because it was informed by the experience of the eight states described above). Congress noted that the ACA's minimum requirement builds upon and strengthens the private employer-based health insurance market and observed that a "similar requirement" in Massachusetts had increased the number of individuals offered employer sponsored coverage, despite an economic downturn. *Id.* Thus, Massachusetts's successful minimum coverage provision was a model for the ACA.

Moreover, empirical data demonstrates that Congress was wise to base the ACA on Massachusetts' experience in order to achieve its overarching goal of near-universal health coverage. Although estimates vary slightly on the percentage of uninsured individuals in Massachusetts, the state is widely acknowledged as having the lowest rate of uninsured individuals in the country. Based on 2009 Census data, Massachusetts had an uninsured rate of 4.4%, the lowest for any state in the country, and significantly lower than the national rate of 16.7%. U.S. Census Bureau, Statistical Abstract of the United States: 2012, Table 156. Persons With and Without Health Insurance Coverage by State: 2009, *available at* http://www.census.gov/compendia/statab/2012/tables/12s0156.pdf.

Other estimates reinforce the success of the Massachusetts model. Massachusetts' minimum coverage provision increased health insurance coverage from 89% of the state's residents in 2006 to 97% in 2008 according to the Centers for Disease Control, Centers for Disease Control and Prevention. Short-Term Effects of Health Care Coverage Legislation – Massachusetts 2008, Morbidity and Mortality Weekly Report, 2010, 59(9), 262-67, *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a3.htm. The state's own data indicates that its uninsurance rate dropped as low as 1.9% by 2010. Massachusetts Division of Health Care Finance and Policy, *Health Care in Massachusetts: Key Indicators*, May 2011 Edition.

As the foregoing evidence demonstrates, the minimum coverage provision is both an essential part of a larger regulation of economic activity and consistent with well-established law. *Raich*, 545 U.S. at 24; *Lopez*, 514 U.S. at 560. Nevertheless, the Eleventh Circuit held it unconstitutional because it believed upholding it would "obliterate[e] the boundaries inherent in the system of enumerated congressional powers." *Florida*, 648 F.3d at 1328. This concern is unfounded.

The minimum coverage provision is at the core of Congress' authority under the Commerce and Necessary and Proper Clauses, not its periphery. It does not touch, let alone cross, any of the outer boundary lines defined in the Constitution and prior Supreme Court cases. As Judge Silberman recognized, nothing in his opinion upholding the minimum coverage provision disturbs the distinctions "between intrastate and interstate commerce, and between traditional, non-economic areas of state concern and those involving commerce" that are both apparent in the text of the Commerce Clause and explicit in this Court's decisions. *Seven-Sky v. Holder*, 661 F.3d 1, 18-19 (D.C. Cir. 2011). Nor, as Judge Sutton explained, "does this approach remove all limits on the commerce power." *Thomas More*, 651 F.3d. at 558 (Sutton, J., concurring in part and delivering the opinion of the Court in part). Unlike the many non-economic regulations which remain entirely unconstitutional under Judges Silberman and Sutton's opinions, "health care and the means of

paying for it are 'quintessentially economic,'" and fit comfortably within Congress' core authority. *Id.*

C. The Eleventh Circuit's Claim that the ACA's Minimum Coverage Provision is Ineffective, and, hence, not Essential is Refuted by the Experience with a Similar Provision in Massachusetts and by Independent Analysis

The Eleventh Circuit concluded that the minimum coverage provision is not "essential" to the ACA, because healthy people can simply pay a penalty for non-compliance or claim one of several exemptions, such as the religious conscience exemption. *Florida*, 648 F.3d at 1311. The court made a further factual determination that the ACA penalties are "toothless," because the law does not contain criminal penalties and prohibits the IRS from filing notice of liens and levying property to collect the penalty. *Id.* In making this determination, however, the Eleventh Circuit both exceeded its legitimate authority as an arm of the judiciary and reached a factually inaccurate conclusion.

This Court's earliest and most recent precedents conclusively establish that it is not the role of the judiciary to engage in a granular critique of a federal law's efficacy. In assessing the effectiveness of the minimum coverage provision, the proper inquiry is not whether it possesses sufficient "teeth." Rather, the Court must sustain the law as long as "Congress had a rational basis for believing that failure to regulate . . . would leave a gaping

hole" in an economic regulatory scheme. *Raich*, 545 U.S. at 22; *see also Turner Broadcasting Sys. v. FCC*, 520 U.S. 180, 196 (1997) ("deference must be accorded to [Congress'] findings as to the harm to be avoided and to the remedial measures adopted for that end, lest [the judiciary] infringe on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy"). Rather than apply the proper legal standard, the Eleventh Circuit "subject[ed] Congress' findings to an analysis that looks startlingly like strict scrutiny review. *Florida*, 648 F.3d at 1343 (Marcus, J., dissenting); *see Liberty University, Inc. v. Geithner*, __ F.3d __, 2011 WL 3962915 at *39 (4th Cir. 2011) (Davis, J., dissenting) (explaining that the impact of the uninsured on interstate commerce "relies on a great number of factual determinations. These are to be made not by the courts but by Congress, an institution with far greater ability to gather and critically evaluate the relevant information."); *see also Seven-Sky v. Holder,* 661 F.3d at 20 (observing that it is "imperative that Congress be free to forge national solutions to national problems" (citing *Heart of Atlanta Motel, Inc. v. United States,* 379 U.S. 241, 258–59 (1964))).

Indeed, the Eleventh Circuit breached limitations on the judiciary's role established since the earliest days of the Republic by substituting its own judgment for that of Congress with respect to whether Congress chose an effective means of regulation. As Chief Justice Marshall held in 1819, the Necessary and Proper Clause

> *cannot* be construed to restrain the powers of congress, *or to impair the right of the legislature to exercise its best judgment in the selection of measures* to carry into execution the constitutional powers of the government. . . . [T]he sound construction of the constitution *must allow to the national legislature that discretion, with respect to the means by which the powers it confers are to be carried into execution*, which will enable that body to perform the high duties assigned to it, in the manner most beneficial to the people. . . . [W]here the law is not prohibited, and is really *calculated to effect any of the objects intrusted to the government, to undertake . . . to inquire into the degree of its necessity, would be to pass the line which circumscribes the judicial department, and to tread on legislative ground*."

McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316, 420-21, 423 (1819) (emphasis added).

Such judicial modesty is grounded in this Court's wise judgment that Congress "is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon legislative questions." *Turner Broadcasting*, 520 U.S. at 195 (internal quotations omitted). This is especially true in a case such as this one, where the statute at issue was enacted after an unusually lengthy and comprehensive congressional inquiry. Indeed, one member of Congress estimates that the House of Representatives alone held 79 hearings on health

reform, debated 238 amendments and heard testimony from 181 witnesses as part of its consideration of the Affordable Care Act. 156 Cong. Rec. H1903 (daily ed. Mar. 21, 2010) (statement of Rep. Holt). Federal courts—especially appellate courts—lack the capacity to conduct such a sweeping policy inquiry.

Moreover, even if it were appropriate for the judiciary to engage in the fundamentally legislative inquiry of determining whether or not the minimum coverage provision's enforcement mechanism is sufficiently stern, the Eleventh Circuit still erred by ignoring considerable evidence indicating that this provision has more than sufficient "teeth" to accomplish its purpose.

As explained above, Massachusetts' minimum coverage provision succeeded in accomplishing the ACA's minimum coverage requirement's goal of permitting comprehensive insurance reforms without triggering a downward spiral of adverse selection. Yet the Massachusetts law's enforcement mechanism is in many ways weaker than the ACA's. In most cases, the penalties for non-compliance with Massachusetts' minimum coverage provision are less steep than the penalties for non-compliance with the ACA's minimum coverage requirement. The average penalty per person in 2016 is estimated to be $537 under the Massachusetts law, compared with the higher average penalty of $674 per person under the ACA. Austin Frakt, *Dispatch from Massachusetts: The Individual Mandate is Working*, Kaiser Health News, July 22, 2010, available at

http://www.kaiserhealthnews.org/Columns/2010/July/072210Frakt.aspx. In addition, the ACA includes a penalty for uninsured children, assessing half the adult penalty, while Massachusetts does not impose any penalty for uninsured children. Robert W. Seifert and Andrew P. Cohen, *Re-Forming Reform: What the Patient Protection and Affordable Care Act Means for Massachusetts*, University of Massachusetts Medical School Center for Health Law and Economics, pp. 12, available at http://masshealthpolicyforum.brandeis.edu/forums/Documents/IssueBrief_ReportFINAL.pdf.

Moreover, Massachusetts' law contains many of the exact same exemptions criticized by the Eleventh Circuit as rendering the ACA minimum coverage provision fatally "porous." 648 F.3d at 1326. The Massachusetts scheme relies on a financial penalty for non-compliance, Mass. Gen. Laws ch. 111M, § 2, proving there is no need for criminal penalties to achieve compliance. The Massachusetts law also has a religious exemption, demonstrating that a religious exemption does not gut the effectiveness of a minimum coverage provision. *Compare* 26 U.S.C. § 5000A(d)(2) *with* Mass. Gen. Laws ch. 111M, § 3. Likewise, both the Massachusetts system and the ACA include exemptions for people likely to experience financial hardship if they comply with the law and for low income individuals. *Compare* 26 U.S.C. § 5000A(e)(5) *with* 830 Code of Massachusetts Regulations (CMR) 111M.2.1(6)(c) (2011).

Furthermore, the Eleventh Circuit's assumption that the Internal Revenue Service ("IRS") cannot collect a penalty under the ACA without filing notice of liens or imposing criminal penalties, 648 F.3d at 1311, is rebutted by the reality of tax code enforcement. The IRS reported to Congress in 2009 that the majority of delinquent taxes recouped from taxpayers are collected through "refund offsets," whereby "the taxpayer filed a return in a subsequent tax year showing a refund due and the IRS withheld the refund to satisfy the past-due tax debt." National Taxpayer Advocate, *2009 Report to Congress*, I.R.S. Pub. No. 2104, at 18 (2009). This mechanism remains available to collect penalties due under the ACA's minimum coverage provision.

Additionally, the Internal Revenue Code automatically places a lien "upon all property and rights to property, whether real or personal, belonging to" a taxpayer who refuses to comply with a request for payment from the IRS. *See* I.R.C. § 6321. Although the ACA prohibits the IRS from filing a notice of a lien,[7] 26 U.S.C. § 5000A(g)(2), nothing in the ACA vitiates the lien automatically placed upon the taxpayer's property if they refuse to comply with a request to pay any penalties owed under the minimum coverage provision. Should the taxpayer sell any property subject to the IRS' lien, IRS could "collect on its claim prior to distribution of the proceeds to anyone other than those with

[7] The notice gives the IRS a superior claim to the taxpayer's property over that of "any purchaser, holder of a security interest, mechanic's lienor, or judgment lien creditor." I.RC. § 6323.

superior claims." Carol A. Pettit & Edward C. Liu, Congressional Research Service, *The PPACA Penalty Provision and the Internal Revenue Service* 6 (April 30, 2011).

Finally, nothing in the ACA vitiates IRS's authority to seek enforcement of the tax code through civil lawsuits filed in a U.S. District Court. *See* I.R.C. § 7402. Accordingly, although the ACA removes a handful of the extraordinary remedies normally available to IRS, tax collectors retain a wide range of tools enabling them to ensure payment of penalties under the minimum coverage provision.

The Eleventh Circuit's dismissal of the minimum coverage provision's enforcement mechanism also runs counter to the predictions of numerous experts with considerable experience evaluating the economic impact of regulation. Contrary to the Eleventh Circuit's suggestion that the minimum coverage provision provides a negligible incentive for individuals to carry insurance, the Congressional Budget Office determined that 16 million people will purchase insurance because of the minimum coverage provision—including 4 to 5 million who will enroll in employer-based coverage. Congressional Budget Office, "Effects of Eliminating the Individual Mandate to Obtain Health Insurance" 2 (June 16, 2010) ("Effects of Eliminating Mandate"). Without the minimum coverage provision, CBO estimates the number of newly insured individuals will be cut in half. *Id.* Similarly, an Urban Institute study found that compliance with the minimum coverage

provision is the single greatest factor driving new insurance enrollments under the ACA. *See* Matthew Buettgens, et al. The Urban Institute, *Why the Individual Mandate Matters* 1 (Dec. 2010) ("[T]he number of uninsured would be cut by more than half with the mandate but by only about 20 percent without the mandate.) And the RAND Corporation concluded that "[e]stimates from scenarios that include each major coverage provision separately . . . indicate that the individual mandate by itself would have the largest impact on coverage, reducing the number of uninsured in 2019 to 31 million." RAND Corporation, *Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)* 8–9 (Feb. 2010).

Expert analysis also demonstrates that excising the minimum coverage provision would dramatically impact premiums. One study predicts that premiums in 2019 are likely to rise 27% without the minimum coverage provision. Jonathan Gruber, "Health Care Reform is a 'Three-Legged Stool,'" (2010), *available at* http://www.americanprogress.org/issues/2010/08/pdf/repealing_ reform.pdf.

In sum, both expert opinion and the success of Massachusetts' health reforms belie the Eleventh Circuit's dismissal of Congress' judgment concerning the effectiveness of the minimum coverage requirement.

II. THE MINIMUM COVERAGE PROVISION, TOGETHER WITH THE PROHIBITION ON EXCLUSIONS FOR PRE-EXISTING CONDITIONS, CAN BE EXPECTED TO REDUCE HEALTH CARE COSTS, PREVENT MEDICAL BANKRUPTCIES, ENCOURAGE FLUIDITY IN THE JOB MARKET, AND REDUCE HUMAN AND ECONOMIC COSTS FROM UNNECESSARY DEATHS

Because the minimum coverage provision is an essential element of the ACA's pre-existing conditions reforms, this Court must uphold it so long as those reforms regulate an activity that substantially affects interstate commerce. *Id.* This point is easily proven. Insurance is an activity subject to regulation under the Commerce Clause, *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 553 (1944), and the ACA's insurance reforms place strict limits on the insurance industry's activities of denying coverage to persons with pre-existing conditions and charging higher premiums to higher risk patients.

The harm from the exclusions for pre-existing conditions cuts across the entire U.S. population. An estimated 57.2 million Americans under the age of 65 have a pre-existing condition. Christine Sebastian et al., *Health Reform: Help for Americans with Pre-Existing Conditions*, Families USA, May 2010, at 2, *available at* http://www.familiesusa.org/assets/pdfs/health-

reform/pre-existing-conditions.pdf ("Help for Americans"). A congressional investigation conducted after passage of the ACA found that the four largest U.S. for-profit health insurers denied policies to one out of every seven applicants based on their prior medical history. H. Comm. on Energy and Commerce Memorandum, 111th Cong., *Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market* 1 (Oct. 12, 2010). Congress also found that pregnant women, fathers-to-be and those attempting to adopt children are generally unable to buy policies on the individual insurance market. *Id.*

A. The Pre-existing Conditions Provision Will Reduce Health Care Costs For Millions of Americans

Many of the 57.2 million Americans with pre-existing conditions currently can be denied coverage outright, forcing them to pay even catastrophic medical costs out-of-pocket. *See* Karen Pollitz et al., *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?,* Kaiser Fam. Found., June 2001, at 31, *available at* http://www.kff.org/insurance/20010620a-index.cfm ("How Accessible") (finding that insurers in the individual market consider certain conditions to be "uninsurable"). Yet even very minor conditions can lead to denials of coverage—one study found that individual insurers will deny coverage to a young, otherwise-healthy woman 8 percent of the time simply because she has hay fever. *Id.* at 7. Likewise, temporary conditions such as pregnancy can be

grounds for complete denial of insurance, *id.* at 19 n.27, potentially imposing enormous unanticipated costs on uninsured women, *see* Committee on Understanding Premature Birth & Assuring Healthy Outcomes, Institute of Medicine, Preterm Birth: Causes, Consequences, and Prevention 398 (2007) ("Preterm Birth") (estimating the total costs of medical treatment for preterm births alone to be $16.9 billion in 2005).

The weight of pre-existing condition exclusions falls particularly hard on women. Women are more likely than men to have chronic conditions. *See* Alina Salganicoff et al., *Women and Health Care: A National Profile*, Kaiser Fam. Found., Jul. 2005, at 8, *available at* http://www.kff.org/womenshealth/7336.cfm. Insurance companies have denied coverage to women based solely on their history of having had a Cesarean section or required them to show proof of sterilization. Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. Times, June 1, 2008, at A26, *available at* http://www.nytimes.com/2008/06/01/health/01insure.html. Survivors of domestic violence may also face pre-existing condition coverage denials, National Women's Law Center, Nowhere to Turn: How the Individual Health Insurance Market Fails Women 8 (2008), *available at* http://nwlc.org/reformmatters/NWLCReport-NowhereToTurn-WEB.pdf.

About 13.5 million children have special health needs, Ha T. Tu & Peter J. Cunningham, *Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs*, Center for Studying Health Sys. Change, Sept. 2005, at 1,

available at http://www.hschange.com/CONTENT/778/778.PDF. But pre-existing conditions are most common among older Americans. Nearly half of all adults between the ages of 55 and 64 have a pre-existing condition, and thus could be denied insurance coverage absent the ACA's pre-existing conditions provision. Help for Americans at 3.

Other individuals with pre-existing conditions will be issued insurance only if they agree to pay increased premiums, accept a higher co-payment or deductible, exclude their pre-existing condition from coverage, accept an annual or lifetime cap on coverage, or all four. How Accessible at i–iii & 24. Insurers typically substantially limit the benefits available to children with long-term health conditions. Treatment such as rehabilitation services, for example, is "usually limited to 3 months after an acute event that usually requires hospitalization." Preterm Birth at 459.

For Americans denied meaningful access to health insurance, every illness is a potential brush with economic ruin. The pre-existing conditions provision will remove this risk, also removing a substantial burden to interstate commerce in the process.

B. The Pre-existing Conditions Provision Will Reduce Medical Bankruptcies

At its core, health insurance exists to "distribute[] risk" away from an individual unfortunate enough to be struck with an expensive

illness or injury and spread these costs among a large pool of individuals. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 239, 99 S. Ct. 1067, 1087 (1979). Without access to insurance, persons with pre-existing conditions are constantly at risk of being struck by an unaffordable hospital bill, forcing them to declare bankruptcy. Likewise, Americans who can afford insurance but choose not to purchase it impose significant burdens on interstate commerce when they subsequently declare bankruptcy to escape from medical bills they cannot afford to pay.

Congress found that "[h]alf of all personal bankruptcies are caused in part by medical expenses," Pub L. No. 111-148 § 1501(a)(2)(E). One study estimates that "62.1% of all bankruptcies have a medical cause," and the share of bankruptcies attributable to such causes increased by 50 percent between 2001 and 2007. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study,* 122 Am. J. of Med. 741, 742 (2007). The pre-existing conditions provision will increase access to insurance, reducing the number of patients hit by catastrophic bills and decreasing the substantial burden medical bankruptcies impose on interstate commerce.

C. The Pre-existing Conditions Provision Will Reduce "Job Lock"

Because employer-provided health plan participants typically enjoy legal protections against exclusion, *see* 29 U.S.C. §§ 1181, 1182, the only way

for many people with pre-existing conditions to secure coverage is to receive insurance through an employer. *See* How Accessible at 19 n.27 (finding that insurers in the individual market consider certain conditions to be "uninsurable"). Thus, absent the pre-existing conditions provision, thousands of American workers will forego a job opportunity because of fear that they will be uninsured if they leave their current job. This "job lock" phenomenon "accounts for a 25–30 percent reduction in [job] mobility." Brigitte C. Madrian, *Health Insurance and Job Mobility: Is There Evidence of Job-Lock?*, 109 Q. J. of Econ. 27, 43 (1994); *see also* Kevin T. Stroupe et al., *Chronic Illness and Health Insurance Related-Job Lock*, 20 J. Pol'y Analysis & Mgmt. 525, 525 (2001) (finding that workers with chronic illnesses or a family member with chronic illness are 40 percent less likely to voluntarily leave a job which provides health benefits than a similarly-situated healthy worker with a healthy family). Moreover, Congress was well aware of job lock when it debated the ACA. *See Terminations of Individual Health Policies by Insurance Companies: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. On Oversight and Investigations*, 111th Cong. (2009) (statement of Jennifer Wittney Horton) ("I have had to take jobs that I do not want, and put my 22 career goals on hold to ensure that I can find health insurance."); President Barack Obama, Address to a Joint Session of Congress (Sep. 9, 2009) ("More and more Americans worry that if you . . . change your job, you'll lose your health insurance too.").

Excluding individuals with pre-existing conditions from coverage stifles entrepreneurship; it leads workers to choose large employers over promising young companies; it forces workers to limit their career path to jobs which offer health benefits; and it discourages workers from going where their talents lead them. By eliminating such exclusions in the individual market, the ACA will significantly reduce—if not eliminate altogether—these substantial burdens to interstate commerce.

D. The Pre-existing Conditions Provision Will Reduce Preventable Deaths

Finally, and most tragically, nearly 45,000 deaths every year are associated with a lack of health insurance. Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 Am. J. Pub. Health 2289, 2295 (2009). Beyond the terrible human tragedies of these deaths, this figure represents tens of thousands of workers whose productive lives are cut short, often leaving their families without a source of income. By increasing access to lifesaving health insurance, the ACA's insurance reforms will prevent many of these tragic deaths, removing a substantial burden on interstate commerce.

III. INDIVIDUALS WHO CHOOSE TO FOREGO INSURANCE SHIFT BILLIONS OF DOLLARS OF COSTS TO OTHER PARTICIPANTS IN THE HEALTH INSURANCE AND SERVICES MARKET, AN ECONOMIC ACTIVITY THAT SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE

Finally, the minimum coverage provision regulates the financing of health care, specifically, individuals' decisions to self-insure or purchase insurance, an economic activity that is in and substantially affects interstate commerce. As Judge Sutton stated, "[S]elf-insurance and private insurance are two forms of action for addressing the same risk. . . . both affect commerce." *Thomas More*, 651 F.3d at 561 (Sutton, J., concurring in part and delivering the opinion of the Court in part). As Congress found, with ample basis, "cost shifting" from the uninsured to people with insurance substantially affects interstate commerce, and thus can be regulated by Congress.

Uninsured individuals fall into three categories: individuals who cannot afford insurance coverage, those who are denied coverage because of pre-existing conditions, and those who choose to forego purchasing insurance in the hope that they will never require expensive medical treatment or that if they do, it will be available in any event. Uninsured individuals seeking care for pre-existing conditions or who have unexpected health care costs due to illness or injury can lead to increased costs for

other, insured Americans. This is because "[t]hose who are uninsured are less likely to get the care that they need when they need it and are more likely to delay seeking care—often until a condition becomes so serious that treatment can no longer be put off." Help for Americans at 9; *see also* Committee on the Consequences of Uninsurance, Institute of Medicine, Health Insurance is a Family Matter 106 (2002) ("Uninsured children often receive care late in the development of a health problem or do not receive any care. As a result, they are at higher risk for hospitalization for conditions amenable to timely outpatient care and for missed diagnoses of serious and even life-threatening conditions.").

Under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, however, a patient who allows his condition to deteriorate until it requires expensive treatment to stabilize must still receive treatment from most emergencies rooms even if he is unable to pay. Cong. Budget Office, Key Issues in Analyzing Major Health Proposals 13 (2008). These high costs of stabilizing a dangerous condition are then distributed to other consumers.

Even the Eleventh Circuit could not ignore the substantial evidence demonstrating that the uninsured shift costs to the insured, thereby impacting commerce. The Eleventh Circuit acknowledged a recent study which demonstrates that a "hidden tax" on health insurance accounts for roughly 8 percent of the average health insurance premium. 648 F.3d at 1245, n.9, citing Ben Furnas & Peter Harbage, *The Cost-shift from the Uninsured*,

Center for Am. Progress, March 24, 2009, *available at* http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf. This cost-shift added, on average, $1,100 to each family premium in 2009 and about $410 to an individual premium. *Id.* In a high-cost state such as Florida, the cost-shift is even greater, increasing annual average family premiums by $1,400 and individual premiums by $510 per year. *Id*. at 2.

For those who can afford health insurance coverage, and choose not to purchase care, the decision to remain uninsured is clearly an economic calculation with adverse consequences for other market participants. Those who opt to self-insure can virtually never guarantee that, when faced with a life-threatening illness or traumatic injury, that they will bear all their health care costs or forego necessary treatment. According to a recent study, the cost of active treatment for prostate cancer had an average 2-year cost of $59,286. E.D.Crawford et al., *A Retrospective Analysis Illustrating the Substantial Clinical & Economic Burden of Prostate Cancer*, 13 Prostate Cancer & Prostatic Diseases 162 (2010). For colorectal cancer patients, the cost of treatment can exceed hundreds of thousands of dollars. The cost of drugs alone can range from $150,000 to $200,000 for a course of treatment. Neal J. Meropol & Kevin A. Schulman, Kevin, A., *Cost of Cancer Care: Issues and Implications*, 25 J. Clinical Oncology 180 (2007), *available at* http://dceg.cancer.gov/files/genomicscourse/meropol-011007.pdf. In comparison, U.S. Census Bureau data shows, median household income for 2007 was

$50,740, and median household net worth in 2007 was $120,300. U.S. Census Bureau, 2010 Statistical Abstract: Income, Expenditures, Poverty & Wealth (2009), *available at* http://www.census.gov/compendia/statab/cats/income_expenditures_poverty_wealth.html.

By enhancing access to insurance, the pre-existing conditions provision increases the likelihood that patients will seek treatment early, and thus will not pass on elevated costs to other consumers. Judge Sutton of the Sixth Circuit emphasized that Congress's enactment of the minimum coverage provision was eminently reasonable, stating: "Faced with $43 billion in uncompensated care, Congress reasonably could require *all* covered individuals to pay for health care now so that money would be available later to pay for *all* care as the need arises." *Thomas More*, 651 F.3d at 557 (Sutton, J., concurring in part and delivering the opinion of the Court in part).

Judge Sutton's conclusion – that Congress' choice of the minimum coverage provision was reasonable and hence beyond the judiciary's authority to overturn – is compelled by two centuries of precedent. The Eleventh Circuit majority's contrary assertion – that the provision is unconstitutionally "overinclusive" – flouts those precedents. In essence, the majority accuses Congress of overestimating the extent to which, in fact, the minimum coverage provision will reduce cost-shifting from uninsured persons to providers, consumers, and governments. *Florida,* 648 F.3d at

1294, 1299-1300. But this approach oversteps long-established boundaries on the authority of courts to second-guess factual judgments underlying statutes implementing the Commerce and Necessary and Proper clauses. As Chief Justice Marshall explained nearly two centuries ago:

> [Where a law] is really calculated to effect any of the objects intrusted to the government, to undertake here to inquire into the degree of its necessity, would be to pass the line which circumscribes the judicial department, and to tread on legislative ground. This court disclaims all pretensions to such a power.

McCulloch v. Maryland, 17 U.S. at 423.

In the instant case, Judge Marcus, in dissent from the Eleventh Circuit's decision, restated the legal standards first articulated by Chief Justice Marshall, and observed further how the Eleventh Circuit majority's analysis is misplaced as a matter of law. He noted that "There is simply no requirement under the Commerce Clause that Congress choose the least restrictive means at its disposal to accomplish its legitimate objectives." 648 F.3d at 1341. In the same vein, Judge Silberman, in his D.C. Circuit decision upholding the minimum coverage provision, noted that ACA opponents' parsing of Congress' policy choices "seems . . . redolent of Due Process Clause arguments . . . [b]ut has no foundation in the Commerce Clause." *Seven-*

Sky, 661 F.3d at 19.[8] In short, Congress had far more than a reasonable basis for concluding that the minimum coverage provision will substantially ameliorate an endemic dysfunction in one of the nation's largest national markets, and no basis exists in law or fact for setting aside that judgment.

CONCLUSION

Amici respectfully submit that the Court should reverse the decision of the Eleventh Circuit with respect to the minimum coverage provision.

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[8] Apart from its impropriety as a matter of law, the Eleventh Circuit majority's critique of Congress' cost-shifting analysis is flawed by numerous factual and conceptual errors. *See* Br. of *Amici Curiae* Economic Scholars In Support of Defendants-Appellees Supporting Affirmance, at 24-28, *Seven-Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011). To note just one particularly revelatory example of the Eleventh Circuit majority's faulty analysis, the decision asserts that all persons currently lacking insurance because of pre-existing conditions must be subtracted from the $43 billion aggregate of costs shifted by the uninsured, because insurers will be required to cover them under the ACA's insurance reform provisions. *Florida*, 648 F.3d at 1299. Here the majority ignores Congress' well-founded judgment that, without the minimum coverage provision, the insurance reform protections will not work, and affordable coverage will remain beyond the reach of many uninsured persons and families.

Respectfully submitted,

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