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No. 10-2388

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

THOMAS MORE LAW CENTER, *et al.*,
Plaintiff-Appellants,

v.

BARACK HUSSEIN OBAMA, *et al.*,
Defendant-Appellees.

On Appeal from the United States District Court for the
Eastern District of Michigan

AMICI CURIAE BRIEF OF THE AMERICAN CANCER SOCIETY, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, AMERICAN DIABETES ASSOCIATION, AND AMERICAN HEART ASSOCIATION, IN SUPPORT OF APPELLEES URGING AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, the American Cancer Society, American Diabetes Association, and American Heart Association state that they are each individually organized under Section 501(c)(3) of the Internal Revenue Code. They are not affiliated with any publicly owned corporation, nor do they have stock owned by a publicly owned company.

The American Cancer Society Cancer Action Network states that it is organized under Section 501(c)(4) of the Internal Revenue Code. It is not affiliated with any publicly owned corporation, and it has no stock owned by a publicly owned company.

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INTERESTS OF *AMICI CURIAE*[1]

The American Cancer Society ("ACS"), and American Cancer Society Cancer Action Network ("ACS CAN"), the American Diabetes Association ("ADA"), and the American Heart Association ("AHA") (collectively, "*Amici*") are the largest and most prominent organizations representing the interests of patients, survivors and families affected by the widespread chronic conditions of, respectively, cancer, diabetes, and heart disease and stroke. These conditions result in a significant portion of the nation's health care spending.

The fight against cancer, diabetes, heart disease, and strokes requires access to affordable, quality health care and to health insurance. *Amici* therefore strongly supported patient access to care and other provisions of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "Act") during its consideration by Congress, and desire to assist the Court in understanding why those provisions of the Act are so important to millions of cancer, diabetes, heart disease, and stroke patients and survivors, as well as their families. Because these diseases are chronic, those living with them are particularly susceptible to discrimination in the rates and terms of health insurance, or to being denied coverage altogether, due to pre-existing medical condition exclusions and adverse rating actions based on their

[1] No person other than the *amici curiae*, their members, or their counsel authored this brief in whole or in part, or contributed money intended to fund its preparation or submission. Counsel for petitioners and respondents have consented to the filing of this brief.

health status. The Affordable Care Act addresses these problems, but cannot succeed in doing so without the minimum coverage provision that the appellants seek to invalidate.

The ACS is the nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. The ACS has three million volunteers nationwide. The ACS seeks to reduce cancer mortality by 50 percent and cancer incidence by 25 percent by 2015. The ACS's extensive scientific findings have established that health insurance status is strongly linked to medical outcomes. Cancer patients with adequate insurance coverage are more likely to be diagnosed at an earlier stage of disease resulting in lower medical costs, more thorough treatment, better outcomes, and lower rates of death. Accordingly, the ACS identified the lack of adequate insurance coverage as a major impediment to advancing the fight against cancer. Along with its nonpartisan advocacy affiliate, ACS CAN, the ACS strongly advocates guaranteeing all Americans adequate, available, affordable health care that is administratively simple. ACS CAN has nearly half a million patient and survivor advocates nationwide, including thousands that participated in efforts supporting enactment of strong patient protections in the Affordable Care Act. During consideration of the Affordable Care Act, ACS CAN was the leading voice for

cancer patients and their families seeking the inclusion of patient protections in the law.

The ADA is a nationwide, nonprofit, voluntary health organization founded in 1940, and has over 485,000 general members, 15,000 health professional members, and 1,000,000 volunteers. Its mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. The ADA is the most authoritative source for clinical practice recommendations, guidelines, and standards for the treatment of diabetes. As part of its mission, the ADA works to improve access to high quality medical care and treatment for all people with and at risk for diabetes. In seeking to prevent diabetes, protect the rights of patients, and improve access to affordable and adequate insurance for people with diabetes, and based on clear evidence that lack of health insurance leads to increased risk of diabetes complications, the ADA supported provisions in the Affordable Care Act that specifically impact people with diabetes. These include provisions to end discrimination, exclusion, and other adverse actions based on pre-existing conditions such as diabetes, to ban rescissions and caps on annual and lifetime benefits, and to develop an essential benefits package.

The AHA is the nation's oldest and largest voluntary health organization dedicated to fighting heart disease and stroke—the first and fourth leading causes of death in the United States. Since 1924, the AHA and its more than 22 million

volunteers and supporters have focused on reducing disability and death from cardiovascular disease and stroke through research, education, community-based programs, and advocacy. The AHA and its American Stroke Association division ("ASA") have set goals to improve the cardiovascular health of all Americans by 20 percent and to reduce cardiovascular disease and stroke mortality by 20 percent by 2020. Based on well-documented research that uninsured and under-insured Americans with heart disease and stroke experience higher mortality rates, poorer blood pressure control, greater neurological impairments and longer hospital stays after a stroke, the AHA /ASA worked to represent the needs and interests of heart disease and stroke patients during the congressional debates on healthcare reform, and supported patient-centered provisions of the Affordable Care Act.

SUMMARY OF ARGUMENT

All Americans use or will use health care services, and the lifetime risks of acquiring one of the diseases or conditions towards which *amici* direct their efforts are very high. Moreover, the costs of treating such serious conditions can often be very high, and are generally beyond the financial means of individuals or families. The question is thus not whether individual Americans will incur health care expenses, but how they will be financed. How these purchases are financed, in turn, has substantial economic effects on interstate commerce because of the distinguishing characteristics of health care and the unique cost-shifting that occurs

in the health care market as a result. Access to health insurance also greatly improves access to health care, and the consequent outcomes for patients with chronic diseases and conditions.

Two central provisions of the Affordable Care Act's regulatory scheme—the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status in the determination of insurance premium rates—are absolutely critical to assuring that patients with chronic diseases and conditions have access to insurance, and hence to quality care. These key provisions were made a part of the Act in response to failures in the health insurance market that left individuals, especially those affected by serious and chronic conditions such as cancer, diabetes, heart disease, and stroke, without insurance and facing burdensome costs and poorer health outcomes. Congress corrected these failures to achieve its broader regulatory goals of protecting patients and reducing costs by improving the availability, affordability, and quality of health insurance. These provisions cannot be effective and successful, however, without the minimum coverage provision.

ARGUMENT

I THE "ACTIVITY-INACTIVITY" DISTINCTION THAT APPELLANTS ADVANCE IS NOT A PRACTICAL WAY TO THINK ABOUT HEALTH INSURANCE AND HEALTH CARE MARKETS

Conceding that under the Commerce Clause Congress may regulate, among other things, "activities that substantially affect interstate commerce," *see Gonzalez v. Raich*, 545 U.S. 1, 16-17 (2005) (citations omitted), appellants contend that the minimum coverage provision seeks to regulate "inactivity" and thus lies outside Congress's power. Appellant Br. at 11-31. They further argue that if the minimum coverage provision is upheld, other "inactivity" could be penalized, and an individual could thus, for example, be forced to buy an automobile or a gym membership. *Id*. at 12, 31.

This proposed "activity-inactivity" paradigm advanced by the Appellants overlooks the unique characteristics of the health care market and the substantial effect of uninsured individuals on the interstate health care and health insurance markets. How individuals finance health care purchases substantially affects interstate commerce, regardless of whether they purchase health insurance, pay out-of-pocket, or rely on government or private funding. Appellants' argument also neglects to account for the significant differences between health care and other goods.

A. Health Care Is Different From Other Consumer Goods And Services

Health care is unlike any other consumer good or service because we often can literally not live without it. Bus rides, carpools and walking can substitute for cars, and a workout DVD for a gym club membership, but there is often no substitute for health care procedures, especially when they are needed most. Additionally, decisions about whether, when, and how to pay for transportation or gym club memberships do not shift costs to third parties. Moreover, consumers cannot opt out of the health care market or decide not to purchase health care because the need for health care is not only difficult to predict, but also practically inevitable. Looking just at the diseases that are the focus of this *amicus curiae* brief, alone:

-- One out of two men and one out of three women will develop some form of cancer in his or her lifetime, even if certain skin cancers and early-stage tumors are excluded. AMERICAN CANCER SOCIETY, CANCER STATISTICS 2010 SLIDE PRESENTATION 19-20 (2010), http://www.cancer.org/Research/CancerFactsFigures/.

-- As of 2007, an estimated 23.6 million Americans had diabetes, CENTER FOR DISEASE CONTROL AND PREVENTION, NATIONAL DIABETES FACT SHEET 2007 5 (2008), http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2007.pdf., and if present trends continue, one in three Americans and nearly one in two African

Americans and Hispanics born in 2000 will develop diabetes in their lifetime. K. M. Venkat Narayan, et al., *Lifetime Risk for Diabetes Mellitus in the United States*, 290 J. AM. MED. ASS'N. 1884, 1888 (2003).

-- By 2050, as many as one in three adult Americans are expected to have diabetes. James P. Boyle, et al., *Projection of the year 2050 burden of diabetes in the US adult population: dynamic modeling of incidence, mortality, and prediabetes prevalence*, POPULATION HEALTH METRICS, Oct. 22, 2010 at 4.

-- An estimated 82.6 million American adults (more than one in three) have one or more types of cardiovascular disease. Veronique L. Roger, et al., *Heart Disease and Stroke Statistics 2011 Update: A Report From the American Heart Association* 187 (2010), *available at* http://circ.ahajournals.org/cgi/reprint/CIR.0b013e3182009701v1/.

-- The lifetime risk for developing cardiovascular disease among those starting free of known disease is two in three for men and greater than one in two for women. *Id.* at 31.

These statistics in combination demonstrate the strong likelihood that, even focusing only on this group of chronic diseases, most people will at some point need health care and participate in the health care market. Without a better and more equitably organized health insurance market, the current barriers to care are

unlikely to be overcome and individuals and their families will continue to bear the burden of substantial costs and worse health outcomes.

Aside from the lack of a substitute for health care and the inevitable need for it, health care is also different from other consumer goods and services because we as a people place it in a different category. Unlike most other goods and services, a person's health, well-being, and chance for positive health outcomes when sick are generally not considered to be best left wholly dependent on that person's ability to pay for health care. For example, we abhor reports of patients diagnosed with cancer who are unable to afford potentially life-saving chemotherapy treatment and are left helpless as their condition worsens. We find it tragic when people with diabetes delay treatment or fail to take needed medications for so long because of the high costs that they are forced to amputate a limb. We are frustrated by the all too common occurrence of people with cardiovascular disease cutting pills and forgoing treatment because they cannot afford to refill their prescriptions or visit a doctor.

These natural, indeed nearly universal, human responses are why the *amici* have drawn hundreds of thousands of members and millions of volunteers and donors to help increase access to quality care for those with debilitating or life-threatening diseases. A person who wants a car he or she cannot afford is unlikely to spark a similar reaction. As organizations dedicated to addressing the

devastating impact of these diseases, we know that life-saving treatments are fundamentally different than the desire to own an automobile or other consumer goods.

B. As A Result Of The Unique Characteristics Of Health Care, The Market For Health Care Involves Significant Cost-Shifting That Has Substantial Economic Effects, Regardless Of Whether Decisions About Financing Health Care Are Characterized As An Activity Or Inactivity

Because of the unique characteristics of health care, Congress has required health care providers in certain instances to provide health care regardless of a patient's ability to pay. *See* Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd. The requirement to provide health care in certain instances, regardless of a patient's ability to pay, coupled with the high cost of health care, often results in the costs to provide care for uninsured and underinsured individuals being shifted to insured patients or government health programs. To provide uncompensated care for uninsured and underinsured patients, health care providers pass the costs onto other participants in the health insurance market, driving up insurance premiums, s*ee* Patient Protection and Affordable Care Act § 1501(a), and, thus, exacerbating problems of higher costs and worse health outcomes caused by the lack of affordable, quality health insurance. This cost-shifting is unique to the market for health care because, unlike an individual's decision not to buy a car

or other consumer goods, third parties often bear the costs of an individual's decision to not buy health insurance.

Congress found that the cost of providing uncompensated care to the uninsured was $43 billion in 2008. *See id.* § 10106(a). Based on the unique characteristics of the health care market, this cost must be shifted to other market participants. Congress also found that cost-shifting from providing uncompensated care resulted in increases to insurance premiums for families by over $1,000 a year on average. *Id.* Moreover, this cost-shifting is neither transparent nor equitable. Regardless of whether an individual's decision about how to finance health care can be characterized as an "activity" or "inactivity," this unique cost-shifting that occurs in the market for health care has substantial economic effects that impact interstate commerce.

II THE MINIMUM COVERAGE PROVISION IS NECESSARY AND PROPER TO IMPLEMENT THE AFFORDABLE CARE ACT'S BROADER REGULATORY SCHEME.

Congress has the authority under the Commerce Clause to regulate interstate insurance markets. *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944). *See* Appellants Br. at 30 (agreeing "that the healthcare delivery system in general and the healthcare insurance markets in particular fall within the Commerce Clause"). Congress also has the authority under the Necessary and Proper Clause, U.S. Const. art. I, §8, cl. 18, to use a "means that is rationally

related to the implementation of a constitutionally enumerated power." *United States v. Comstock,* 130 S. Ct. 1949, 1956 (2010).

Appellants do not contest that two features of the Affordable Care Act of particular importance to *amici* — the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status in determining insurance premium rates—were enacted pursuant to Congress's Commerce Clause authority to regulate the interstate health insurance market. These features are critically important to the Affordable Care Act's regulatory scheme intended to provide protections to patients and reduce costs by improving the availability, affordability, and quality of health insurance. However, they cannot be implemented workably without the minimum coverage provision. For that reason, the minimum coverage provision is not only rationally related to Congress's exercise of its authority to regulate the interstate health insurance market, it is essential to the success of Congress's broader regulatory scheme.

A. The Affordable Care Act Addresses Failures Of The Interstate Health Insurance Market That Hurt Patients And Contribute To The High Cost Of Health Insurance And Health Care

The debate over health care reform and Congress's enactment of the Affordable Care Act were spurred by the failures and high costs of the interstate health insurance and health care markets. These failures hurt not only the nation's economic well-being, but the health and well-being of individual Americans. One

of the failures of the health insurance market that led to the nation's healthcare crisis involved the insurance industry's severe medical underwriting practices that often left those most in need of care without adequate health insurance. Reforming the health insurance industry to protect patients against such discriminatory practices was a primary focus of the *amici* and of Congress.

1. The Act addresses the problem of cancer, diabetes, heart disease, and stroke patients and survivors who want and need health insurance but often cannot obtain it

The cost of services to treat cancer, diabetes, heart disease, and stroke can be beyond the reach of all but the wealthiest individuals absent some form of insurance. These chronic conditions have significant financial implications for cancer, diabetes, heart disease, and stroke patients and survivors as well as their families. The costs for necessary health care can be so high that even insured patients can face very significant expenses. For example, 5 percent of even privately insured breast cancer patients had total out-of-pocket costs that exceeded $31,264. Karen Pollitz et al., *Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes* 7 (Georgetown University Health Policy Institute and the American Diabetes Association) (2005) *available at* http://healthinsuranceinfo.net/diabetes_and_health_ins_exec_summ.pdf. The high cost of treating cardiovascular disease is also a leading cause of medical bankruptcy. David U. Himmelstein, et al., *Medical Bankruptcy in the United*

States, 2007: Results of a National Study, 122 AM. J. MED. 741 (2009). Among families with high levels of medical debt resulting in bankruptcy, those with stroke had average out-of-pocket medical costs of $23,380 and those with heart disease had average medical costs of $21,955. *Id.* at 745.

To be better able to handle the high costs associated with cancer, diabetes, heart disease, and stroke, patients and survivors want and need health insurance, but have often been unable to obtain health insurance or find an adequate, affordable health insurance plan to cover their costs. Without the Affordable Care Act's provisions banning pre-existing condition exclusions and prohibiting discrimination based on health status in the determination of health insurance rates, cancer, diabetes, heart disease, and stroke patients and survivors often reported being denied health insurance or offered only health insurance with significantly higher insurance premiums. For example, a prostate cancer survivor who has been cancer-free for over ten years voiced his frustration to the ACS over insurers refusing him health insurance, saying "after cancer you may as well kiss your way of life and your family's way of life goodbye, because no one wants to talk to you about getting comprehensive, affordable coverage." Karyn Schwartz et al., *Spending to Survive: Cancer Patients Confront Holes in Health Insurance System* 17 (Kaiser Family Foundation and the American Cancer Society) (2009) *available at* http://www.kff.org/insurance/upload/785.pdf.

The problem is not merely anecdotal. One of every three people diagnosed with cancer under age 65 are uninsured or have been uninsured at some point since diagnosis. AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, *A National Poll: Facing Cancer in the Health Care System* (2010) *available at* http://www.ascan.org/healthcare/cancerpoll. Of the cancer patients who reported being uninsured, 75 percent attributed their lack of health insurance to affordability or pre-existing condition exclusions. *Id.*

Similarly, approximately 6.5 million (or 15 percent) of adults who report having cardiovascular disease are uninsured, and more than half of the uninsured with cardiovascular disease cite cost as the reason they lack coverage. Raymond J. Gibbon, et al., *The American Heart Association's 2008 Statement of Principles for Healthcare Reform*, 118 J. AM. HEART ASS'N. 2209 (2008). Additionally, between 10 percent and 22 percent of adults with congenital heart disease are uninsured, and 67 percent have reported difficulty in obtaining health insurance or changing jobs to guarantee coverage. David J. Skorton, et al., *Task Force 5: adults with congenital heart disease: access to care,* 37 J. AM. C. CARDIOLOGY 1193, 1195 (2001). Many individuals with diabetes also report being unable to obtain any individual health insurance because of their diabetes, or being offered policies which are significantly more expensive than those for people without diabetes. Karen Pollitz et al., *Falling Through the Cracks: Stories of How Health Insurance*

Can Fail People with Diabetes 9-12. The recent recession has only magnified problems for cancer, diabetes, heart disease, and stroke patients and survivors because employer-sponsored insurance covers more than half of all people under age 65, and the rise of unemployment put many individuals' health insurance at risk. *See* Karyn Schwartz, et al., *Patients Under Pressure: Profiles of How Families Affected by Cancer Are Faring in the Recession* 1 (Kaiser Family Foundation and the American Cancer Society) (2009) *available at* http://www/kff.org/insurance/7934.pdf.

There is also a tremendous problem with individuals being underinsured. Nearly one in three (or 28.8 percent) of cancer patients who are insured have an out-of-pocket health care burden that exceeds 10 percent of their family income. Jessica S. Banthin & Didem M. Bernard, *Changes In Financial Burdens for Healthcare: National Estimates for the Population Younger Than 65 Years,* 296 J. AM. MED. ASS'N. 2712, 2717 (2006). More than one in nine cancer patients with insurance have out-of-pocket health care burdens exceeding 20 percent of their family income in health care expenditures. *Id*. More than a third (39.1 percent) of households that include an individual with diabetes have health care costs totaling 10 percent or more of household income, while 18 percent of such households have costs totaling 20 percent or more of household income. *Id.* This high cost to the underinsured has led to numerous bankruptcies due to medical expenses. *See*

David U. Himmelstein, et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, Health Affairs, Feb. 2, 2005 at 69.

To address the problem of underinsurance the Affordable Care Act includes several provisions that, in combination with the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status, improve the availability, affordability, and quality of health insurance and health care. These include a framework for an essential benefits package and the elimination of lifetime and annual limits. *Are Mini-Med Policies Really Health Insurance*: *Hearing Before the S. Comm. on Commerce, Sci. and Transp.*, 111th Cong. 5-6 (2010) (statement of Stephen Finan, American Cancer Society Cancer Action Network). Additionally, the Act offers subsidies to assist individuals and families below 400 percent of the federal poverty level and requires limits on out-of-pocket expenses in all insurance plans, except those that are grandfathered. *Id.*

2. Without adequate health insurance, people have poorer health outcomes and require more costly health care

The lack of adequate and affordable health insurance has serious consequences for cancer, diabetes, heart disease, and stroke patients and survivors. Individuals without health insurance are less likely to receive preventative treatment or early detection screenings and are more likely to delay treatment.

For example, in a 2010 ACS poll of individuals under age 65 who have cancer or a history of cancer, 34 percent reported delaying care because of cost in

the past 12 months. AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, *A National Poll: Facing Cancer in the Health Care System* (2010). More specifically, 29 percent delayed needed health care, 19 percent delayed getting a recommended cancer test or treatment, and 22 percent delayed a routine cancer check-up. *Id.* At every level of education, individuals with health insurance are about twice as likely as those without it to have access to key cancer early detection procedures, such as mammography or colorectal screenings. Elizabeth Ward, et al., *Association of Insurance with Cancer Care Utilization and Outcomes*, 58 CANCER J. FOR CLINICIANS 9 (2008).

With respect to heart disease, an AHA survey found that more than half of the cardiovascular patients responding reported difficulty paying for medical care. Of those reporting difficulty paying for medical care, 46 percent said they had delayed getting needed medical care, 43 percent had not filled a prescription, and 31 percent had delayed a screening test. Synovate, *Advocacy Survey Among CVD & Stroke Patients* 23 (American Heart Association) (2010) *available at* http://americanheart.org/presenter.jhtml?identifier=3072496. Even during a heart attack, studies show that uninsured patients are more likely to delay seeking medical care. Kim G. Smolderen, et al., *Health Care Insurance, Financial Concerns in Accessing Care, and Delays to Hospital Presentation in Acute Myocardial Infarction*, 303 J. AM. MED. ASS'N. 1392, 1395-99 (2010).

The same patterns occur among uninsured individuals with diabetes. For example, among persons aged 18 to 64 with diabetes mellitus, those who had no health insurance during the preceding year were six times as likely to forgo needed medical care as those who were continuously insured. JB Fox, et al., *Vital Signs: Health Insurance Coverage and Health Care Utilization—United States, 2006-2009 and January-March 2010,* 59 MORBIDITY AND MORTALITY WKLY. REP. 1448, (2010). Lack of health insurance also leads to cases of diabetes going undiagnosed, delaying the start of needed treatment and increasing the risks of complications. Among those with diabetes, 42.2 percent of those without health insurance were undiagnosed, compared with 25.9 percent for those with insurance. Xuanping Zhang, et al., *The Missed Patient with Diabetes: How Access to Health Care Affects the Detection of Diabetes*, 31 DIABETES CARE 1748, 1749 (2008).

As result of lack of preventative care and delayed treatment, uninsured patients have poorer outcomes and require more costly long-term and invasive treatment than individuals with insurance. For example, in a multivariate analysis including sex, age, type of treatment facility, location of residence, median household income in zip code of residence, and education level, health insurance status was the strongest predictor of oropharyngeal cancer and tumor size at diagnosis, with uninsured patients having the greatest likelihood of advanced disease stage at diagnosis. Amy Y. Chen et al., *The Impact of Health Insurance*

Status on Stage at Diagnosis of Oropharyngeal Cancer, 110 CANCER 395, 400-01 (2007). Similarly, patients who are uninsured have substantially elevated risks of being diagnosed with advanced stage breast cancer compared with privately insured patients. Michael T. Halpern, et al., *Insurance Status and Stage of Cancer at Diagnosis Among Women with Breast Cancer*, 110 CANCER 403, 409 (2007). Cancer patients diagnosed at an advanced stage experience lower survival, more debilitating, invasive treatment, and greater long-term treatment-related morbidity. *Id.* at 408.

Likewise, uninsured patients with cardiovascular disease experience higher mortality rates and poorer blood pressure control than their insured counterparts. Jay J. Shen & Elmer L. Washington, *Disparities in outcomes among patients with stroke associated with insurance status*, 38 STROKE 1010, 1013 (2007); J. Michael McWilliams, et al., *Health insurance coverage and mortality among the near-elderly*, 23 HEALTH AFFAIRS 223, 229 (2004); O. Kenrik Duru, et al., *Health insurance status and hypertension monitoring and control in the United States*, 20 AM. J. HYPERTENSION 348 (2007). Those who suffer a stroke who are uninsured experience greater neurological impairments, longer hospital stays and up to a 56 percent higher risk of death than the insured. Shen, *supra*, at 1013. Patients with no health insurance were also twice as likely to have a diabetic complication as

patients who had insurance. Nina E. Flavin, et al., *Health Insurance and the Development of Diabetic Complications,* 102 SO. MED. J. 805 (2009).

In sum, there can be no doubt that Congress acted to address serious shortcomings in the health insurance market.

B. The Minimum Coverage Provision Is Essential To The Implementation Of Two Key Provisions Of The Act That Correct The Failures Of The Interstate Health Insurance Market And Improve The Availability, Affordability, And Quality Of Health Insurance

To address the failures of the health insurance market and the tragic consequences they have for individuals, especially cancer, diabetes, heart disease, and stroke patients and survivors, Congress enacted the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status. The ban on pre-existing condition exclusions ensures that all individuals are able to participate in the health insurance market and protects individuals from being forced out of the market based on risk. The prohibition of discrimination based on health status similarly protects patients from being priced out of the health insurance market based on risk.

By ensuring that health insurance is available to all individuals regardless of prior history, the Affordable Care Act protects patients with chronic conditions from the negative health and financial outcomes that accompany being uninsured or underinsured. However, the effective implementation of these provisions is

critical; otherwise cancer, diabetes, heart disease, and stroke patients and survivors will continue to be plagued by the serious financial and health consequences associated with the lack of adequate health insurance.

Congress recognized, and the appellants do not contest, that the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status must be coupled with the minimum coverage provision to be effective in achieving the patient protections, cost reductions, elimination of inequitable cost shifting, and improvements to health insurance Congress intended. Affordable Care Act, § 10106(a). Congress explained that "if there were no [minimum coverage provision], many individuals would wait to purchase health insurance until they needed care" because the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status guarantee that individuals will be issued health insurance regardless of their health history or status. *Id.*

The adverse selection that would result from the decoupling of the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status from the minimum coverage provision could ultimately collapse the health insurance industry. Insurance pools would be populated by individuals who are ill and thus drive the cost of coverage to unsustainable levels creating a death spiral in the industry as fewer and fewer healthy people choose (or are able) to buy very expensive coverage before they actually become ill. The Affordable Care

Act's two central provisions thus must be combined with the minimum coverage provision to mitigate the problematic cost-shifting that occurs in the health care market and ensure that everyone shares in the financing of health care. Only through the minimum coverage provision will adverse selection be minimized, and costs spread more broadly across current and potential participants in the health care market to reduce the cost of health insurance overall, thus enabling the achievement of goals of Congress's broader regulatory scheme.

The minimum coverage provision is also essential to the effective implementation of the pre-existing condition exclusion ban and the elimination of discrimination based on health status because it allows the health insurance market to be restructured around competition based on price, quality, and value, instead of the risk segmentation that prevailed prior to the enactment of the Affordable Care Act. For these reasons, the minimum coverage provision is not just "necessary and proper" for the execution of the Affordable Care Act's ban on pre-existing condition exclusions and the prohibition of discrimination based on health status, but is absolutely essential to their successful implementation.

CONCLUSION

For the reasons stated herein, *amici* respectfully submit that the district court's judgment should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS AND TYPE STYLE REQUIREMENTS

This *amici curiae* brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because this brief contains 5,083 words, excluding the parts of the *amici curiae* brief exempted by Fed. R. App. P. 32(a)(7(B)(iii).

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CERTIFICATE OF SERVICE

I hereby certify that on this 21st day of January, 2011, I caused the foregoing brief to be filed and served through the Court's CM/ECF system.

*/s/ Molly Suda*_____________

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