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Kinder v. Geithner - States' Amicus Brief

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No. 11-1973

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETER KINDER, *et al.*,

Plaintiffs-Appellants,

v.

TIMOTHY GEITHNER, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Missouri
(Rodney W. Sippel, U.S. District Judge)

BRIEF OF THE STATES OF MARYLAND, CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, IOWA, NEW YORK, OREGON, AND VERMONT, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF DEFENDANTS-APPELLEES

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INTEREST OF AMICI STATES

Amici, the States of Maryland, California, Connecticut, Delaware, Hawaii, Iowa, New York, Oregon, and Vermont, and the District of Columbia, have a strong interest in protecting and promoting the health, safety, and welfare of their

citizens, an interest that the Affordable Care Act ("ACA") advances in vitally important ways.[1] The Amici States also have a compelling interest in ensuring that constitutional principles of cooperative federalism are validated when Congress seeks to address important national problems by enacting legislation that will be implemented through the joint participation of the federal government and the states, as Congress has done here.

The Amici States have each made concerted efforts to address the extraordinary problems associated with the current system of healthcare delivery in the United States, including spiraling costs, limitations on the availability of insurance coverage, and restricted access to medical services. Although the Amici States have achieved modest successes, these state-by-state efforts cannot fully counteract the force of inexorable national trends, driven by problems that are fundamentally interstate in nature. The experience of the Amici States demonstrates not only the propriety but the necessity of a national solution that enables states to better protect their citizens by working hand-in-hand with the federal government.

The district court correctly determined that the plaintiffs in this case lack Article III standing to challenge the constitutionality of the ACA, and the Amici States urge affirmance on that basis. However, because the plaintiffs have asked

[1] The Amici States submit this brief in accordance with Federal Rule of Appellate Procedure 29(a).

this Court to address their claims on the merits, and specifically have contended that the ACA unconstitutionally usurps state authority,[2] the Amici States submit this brief to explain their view that the ACA bolsters, rather than usurps, state authority to address problems in the national healthcare economy that states cannot solve effectively on their own.

The ACA is a valid exercise of Congress's power under the Commerce Clause and one that embraces laudatory principles of cooperative federalism. The law strikes an appropriate, constitutional balance between federal and state authority over the healthcare system by creating federal requirements, backed by federal funding, to expand access to affordable coverage, while conferring considerable latitude for states to design systems that work best for their citizens.

Accordingly, the Amici States do not view the ACA as an incursion on state sovereignty—quite the opposite. The Amici States regard the ACA as an indispensable aid to their own efforts to tackle healthcare problems they all face. The framework established by the ACA empowers states to create enduring

[2] The plaintiffs and some of their amici urge the Court not only to consider the merits, but to declare the ACA unconstitutional and direct entry of judgment in the plaintiffs' favor. The plaintiffs did not move for summary judgment below, however. Accordingly, if the Court finds their allegations sufficient to establish standing and to state a claim, the proper disposition is to remand for further proceedings, *see Fountain v. Filson*, 336 U.S. 681, 683 (1949) (disapproving appellate order directing summary judgment in favor of non-movant), particularly since a litigant must demonstrate standing "with the manner and degree of evidence required at the successive stages of the litigation," not merely at the pleading stage, *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992).

solutions to those problems, and to do so with federal support. Therefore, if this Court reaches the merits of the plaintiffs' claims, the Court should affirm and uphold the constitutionality of the ACA.

STATUTORY BACKGROUND

The ACA embodies a necessarily nationwide approach to addressing the nation's healthcare crisis and to achieving a more rational, market-based system for paying for health care. The ACA relies in large part on an expansion of the current market mechanisms for delivering health care, building on existing state and federal partnerships to expand access and improve quality in the delivery of healthcare services. These reforms will result in broader healthcare coverage, reductions in state and private expenditures for uncompensated care, and improved quality of care. The minimum-coverage provision, which requires non-exempt adults to maintain adequate health coverage, is an integral component of this comprehensive healthcare reform.

Under the ACA, most people will continue to receive coverage through their employers, through Medicare, or through expanded access to Medicaid. The ACA creates incentives to expand employer-provided health insurance, the principal private mechanism for healthcare financing, by requiring large businesses to provide health insurance, beginning in 2014, 26 U.S.C. § 4980H, and by creating tax incentives for small businesses to do so, 26 U.S.C. § 45R. Many small

businesses have already started taking advantage of these incentives, including some of the 362,731 eligible businesses in the Eighth Circuit.[3]

The ACA also expands access to health care by extending Medicaid eligibility to citizens whose income falls below 133% of the federal poverty level, and the law funds 100% of the additional cost of this program until 2017. 42 U.S.C. § 1396a. Some states, like Maryland and California, have already obtained waivers from the federal government that allow them to offer this expanded coverage before 2014.

Finally, for people who do not obtain health insurance from their employers or from expanded programs administered jointly by the state and federal governments, the ACA makes affordable coverage more readily available, in several ways. The ACA curtails current industry practices that exclude large segments of the population from affordable health insurance, by eliminating caps on benefits that can result in the loss of coverage during a catastrophic illness. 42 U.S.C. § 300gg-11. Additionally, the ACA authorizes states to create health insurance exchanges that will allow individuals, families, and small businesses to leverage their collective bargaining power to obtain more competitive prices and benefits. 42 U.S.C. § 18031. Maryland and Iowa have already received federal

[3] http://www.irs.gov/pub/newsroom/count_per_state_for_special_post_card_notice.pdf (last accessed August 18, 2011).

grants to support their implementation of this provision. The ACA also provides tax benefits to assist low-income individuals in obtaining insurance through these exchanges. 26 U.S.C. § 36B. Starting in 2014, the ACA will prohibit insurance companies from refusing coverage based on preexisting conditions. 42 U.S.C. § 300gg-3. A substantial number of the uninsured are presently unable to purchase insurance or are required to pay higher premiums due to preexisting conditions, such as heart disease, asthma, and even pregnancy.[4] The ACA will thus dramatically increase the availability of insurance for previously uninsurable individuals.

One component of these comprehensive reforms is the minimum-coverage provision, sometimes referred to as the "individual mandate," which is the principal basis for the plaintiffs' constitutional challenge in this case. That provision requires, subject to certain exemptions, that a person maintain "minimum essential coverage" each month. 26 U.S.C. § 5000A. Minimum essential coverage includes Medicare or Medicaid, an employer-sponsored plan, or a plan offered through a health insurance exchange. *Id.* As discussed below, the minimum-coverage provision is important for two reasons. First, it ensures that individuals take responsibility for their own care rather than shift those costs to society.

[4] Karen Pollitz, Richard Sorian, & Kathy Thomas, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Report to the Kaiser Family Foundation, June 2001).

Second, it makes other vital elements of the ACA's comprehensive reforms sustainable, including the prohibition of exclusions based on preexisting conditions and the elimination of caps on benefits.

ARGUMENT

I. THE COMMERCE CLAUSE ENABLES CONGRESS TO ACT ON INTERSTATE PROBLEMS THAT STATES CANNOT EFFECTIVELY ADDRESS ALONE.

By deliberate design, Congress's enumerated power to regulate interstate commerce allows the federal government to address problems that states cannot solve acting alone.[5] America's healthcare crisis is such a problem. Where, as in the ACA, Congress has exercised its commerce power to act in partnership with the states to confront problems with both interstate and intrastate dimensions, Congress honors, rather than transgresses, the structural limitations embodied in the Constitution. The ACA exemplifies this spirit of cooperative federalism.

A. The Framers Understood that the National Government Needed the Power to Solve Interstate Problems.

The Commerce Clause's grant of broad power to Congress to "regulate Commerce . . . among the several States" reflected lessons learned from the failure

[5] *See* Jack M. Balkin, *Commerce*, 109 Mich. L. Rev. 1, 6 (2010) ("[T] he commerce power authorizes Congress to regulate problems or activities that produce spillover effects between states or generate collective action problems that concern more than one state.").

of the Articles of Confederation. Under Article IX of the Articles of Confederation, the states themselves regulated commerce. Without a mechanism for the federal government to coordinate and facilitate interstate commerce, the states were hindered in their ability to confront problems with interstate dimensions. As James Madison observed, a major "defect" in this arrangement was its inability to facilitate action in "concert in matters where common interest requires it," particularly with regard to "our commercial affairs." James Madison, *Vices of the Political System of the United States*, in 9 *The Papers of Madison* 348-50 (Robert A. Rutland *et al.*, eds., 1975). Without coordinated interstate action, a patchwork of state laws "restrict[ed] the commercial intercourse with other States"; this arrangement frustrated economic development and was "destructive of the general harmony." *Id.*

This structural defect led Madison and his fellow Framers to advocate for a new Constitution under which the national government would have the power to "[m]aintain[] . . . harmony and proper intercourse among the States." *The Federalist No. 41* (J. Madison) (Clinton Rossiter ed., 1961).[6] Though some

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

contemporaries advocated stronger limitations on Congress's powers, the committee of the Constitutional Convention that drafted Article I, Section 8 adopted the approach that Madison and the Virginia delegation had proposed. Under their proposal, Congress would have the power "to legislate in all cases to which the separate States are incompetent, or in which the harmony of the United States may be interrupted by the exercise of individual Legislation."[7]

The powers enumerated in Article I, Section 8—including the power to "regulate Commerce . . . among the several States"—overcame shortcomings in the previous system by enabling the federal government to address problems that the states could not effectively resolve through uncoordinated, state-by-state action.[8] *See Gonzales v. Raich*, 545 U.S. 1, 16 (2005) ("The Commerce Clause emerged as the Framers' response to the central problem giving rise to the Constitution itself: the absence of any federal commerce power under the Articles of Confederation."); *see also Kansas City S. Ry. Co. v. R.R. Comm'rs*, 106 F. 353, 355 (C.C.W.D. Ark. 1901), *aff'd* 187 U.S. 617 (1903) (avoiding state interference

[7] 1 *The Records of the Federal Convention of 1787* 21 (Max Farrand ed., 1937) (May 29) (notes of James Madison); *see also* Deborah Jones Merritt, *Textualism and Federalism: The Third Translation of the Commerce Clause: Congressional Power to Regulate Social Problems*, 66 Geo. Wash. L. Rev. 1206, 1210-11 (1998).

[8] *See* Merritt, 66 Geo. Wash. L. Rev. at 1210 ("The powers enumerated in Article I, Section 8 have a unifying theme: they all concern subjects that the states cannot regulate effectively by themselves."); *see also* Larry D. Kramer, *Madison's Audience*, 112 Harv. L. Rev. 611, 619 (1999).

with "commerce . . . among the states was one of the great objects of the framers"). James Wilson, a delegate to the Convention and a future Supreme Court Justice, reported that, in "drawing a proper line" between state and federal powers, the delegates found it "easy to discover a proper and satisfactory principle on the subject": An "object of government" whose "operation and effects [occur] within the bounds of a particular state" is a matter for that state's government, whereas an "object of government [that] extends in its operation or effects beyond the bounds of a particular state" is a matter for the federal government. James Wilson, *Commentaries on the Constitution* 31 (1792).

B. The Supreme Court Has Interpreted the Commerce Clause as a Means of Enabling Congress to Address Problems that Require Coordination and Cooperation Among the States.

Throughout our nation's history, the Supreme Court has consistently interpreted the commerce power as one intended to address problems that require coordination among states, where states, acting alone, can create problems affecting other states. In the seminal case of *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 195 (1824), the Court recognized that the commerce power was necessary to prevent one state from stifling the development of both another state's commerce and interstate commerce in the United States generally. In *Gibbons*, Chief Justice Marshall wrote that commerce "among" the states meant commerce of one state "intermingled" with that of others, and that such commerce necessarily "cannot

stop at the external boundary of each State." 22 U.S. at 194. Without federal power to coordinate this intermingled commerce, actions by one state could negatively affect commerce in another state or among states. Therefore, the Court held, the Commerce Clause must be understood as granting Congress the power to regulate "that commerce which concerns more states than one." *Id.*

As the nation's economy evolved and became more interdependent, the Supreme Court recognized that even small intrastate transactions could undermine laws regulating interstate commerce. In *Wickard v. Filburn*, the Court upheld the application of federal price-stabilization laws to a single farmer's production of wheat for home consumption, finding that the effect of his contribution to the wheat market, when "taken together with that of many others similarly situated, is far from trivial." 317 U.S. 111, 128 (1942). The Court held that the commerce power "extends to those activities intrastate which so affect interstate commerce . . . as to make regulation of them appropriate means to the attainment of a legitimate end, the effective execution of the granted power to regulate interstate commerce." 317 U.S. at 124 (citation omitted).

The Court has also recognized that a single state can put itself at a competitive disadvantage with other states if it seeks to address a general societal ill while other states fail to take action. In *United States v. Darby*, the Court held that federal wage-and-hour regulations were necessary to prevent unfair

competition between businesses in states with such laws and those in states without them, and that such regulations were within Congress's commerce power. *See* 312 U.S. 100, 115 (1941). A state-by-state approach to eradicating "the evils . . . of substandard labor conditions" would result in the "dislocation of the commerce itself caused by the impairment or destruction of local businesses" seeking to compete in a system of interstate commerce. *Id.* at 122. Only Congress, exercising its commerce power, can legislate a solution while maintaining a level playing field among the states.

Supreme Court precedent establishes that states, acting alone within their borders, cannot effectively address certain problems without the coordinating role that Congress can play through the exercise of the commerce power. *See also, e.g.*, *Raich*, 545 U.S. at 17-19. As the Court explained in *United States v. South-Eastern Underwriters Association*, the commerce power encompasses "the power to legislate concerning . . . transactions which, reaching across state boundaries, affect the people of more states than one; – to govern affairs which the individual states, with their limited territorial jurisdictions, are not fully capable of governing." 322 U.S. 533, 552 (1944). The nation's healthcare crisis is one that states, acting within their jurisdictions, are "not fully capable of governing."

C. America's Healthcare Crisis Is an Interstate Problem that States Are Unable to Solve on their Own, and Is Thus a Proper Subject for the Exercise of the Commerce Power.

The interstate nature of the market for health care is beyond serious dispute. The healthcare industry accounts for 17.6% of the nation's gross domestic product, or $2.5 trillion.[9] Many hospital corporations operate in numerous states, and medical supplies, drugs, and equipment routinely cross state lines. 42 U.S.C. § 18091(a)(2)(B). Spending for health insurance exceeded $850 billion in 2009, and the majority of health insurance is sold by national or regional companies. *Id*. And, as Congress found, the economic impact of the interstate market for health care is national in scope, with tens of billions of dollars being spent every year on care for the uninsured. 42 U.S.C. § 18091(a)(2)(F).

The devastating effects of our broken healthcare system cannot be countered through state-by-state solutions alone. As an initial matter, many potential state solutions are preempted by federal law. The Employee Retired Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, precludes many state regulations that affect employee healthcare benefit plans of large, self-insured employers that operate in multiple states, severely reducing the efficacy of any single-state solution. 29 U.S.C. § 1144(a); *see New York State Conf. of Blue Cross*

[9] Centers for Medicare & Medicaid Services, 2009 National Health Expenditure Data, table 3.

& Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1999). In Maryland, for example, approximately 60% of employees under 65 years old get coverage through large, self-insured employers. Thus, while Maryland, like most states, has mandated certain insurance benefits by statute or regulation, these mandates do not apply to nearly two-thirds of the State's non-elderly working population because of ERISA preemption. ERISA also limits the ability of states to offset healthcare costs that they absorb as the result of care provided to inadequately insured employees of large, self-insured employers. *See Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 193-94 (4th Cir. 2007).

Many state solutions for controlling costs are precluded by other federal laws and policies. This is because many key healthcare cost drivers—like coverage limits and drug prices—are determined by policies set by federal agencies such as the Centers for Medicare and Medicaid Services, as a major healthcare purchaser, and the FDA, as a major regulator of drug marketing.

Federal constraints aside, state-level experiments with imposing coverage requirements on employers, in-state insurers, or individuals all run the risk of putting some states at a competitive disadvantage compared to states without such requirements. A state that requires employers or insurers to provide coverage could induce employers and insurers to exit the state. *See Florida v. United States Dep't of Health & Hum. Servs.*, Nos. 11-11021, 11-11067, 2011 U.S. App. LEXIS

16806, at *365-66 (11th Cir. Aug. 12, 2011) (Marcus, J., dissenting) (discussing experience of state-level healthcare reform that led to insurers exiting the market); *see also* Brief of Appellees at 35-36. This is an especially grave concern in states with few carriers in the market; in North Dakota, for example, the largest health insurer has a 91% market share.[10] Similarly, a state that requires its residents to obtain minimum coverage may induce some residents—those who view themselves as having the least need for health insurance—to exit, skewing the risk pool upward for the remaining state residents and increasing health insurance premiums.[11]

Cash-strapped states are already covering the enormous cost incurred by health care provided to the uninsured. In 2009, more than 7.2 million Californians—nearly one in four people under the age of 65—lacked insurance for all or part of the year. More than 5.5 million Californians who could not afford

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[10] Letter from United States Government Accountability Office to Sen. Snowe, *Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market* (Feb. 27, 2009).

[11] Although Massachusetts has achieved a measure of success with a minimum-coverage provision, this is due to a unique set of circumstances. *See* Neil S. Siegel, *Free Riding on Benevolence: Collective Action Federalism & the Individual Mandate* 53-55 (Duke University School of Law, Working Paper Series, 2011), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1843228. Moreover, as Massachusetts has explained, it "cannot effectively account for, let alone mitigate, the interstate (and international) economic implications of current healthcare trends" on its own. Amicus Brief of the Commonwealth of Massachusetts at 12, *Virginia v. Sebelius*, No. 11-1057 (4th Cir. March 7, 2011).

private insurance were enrolled in government-sponsored health plans, which will cost the State a projected $42 billion in the next fiscal year. Of those funds, $27.1 billion comes from the General Fund, which faces a $25 billion deficit.

Oregon and Maryland are also grappling with the spiraling cost of medical care and health insurance. Despite a variety of legislative efforts to increase access to insurance coverage, 21.8% of Oregonians and 16.1% of Marylanders lack health insurance. Without comprehensive healthcare reform, these numbers are expected to rise to 27.4% and 20.2%, respectively, by 2019; Oregon's spending on Medicaid and the Children's Health Insurance Program is expected to more than double, to $5.5 billion, in that period. In 2009, Maryland's hospitals provided $999 million in uncompensated care to the uninsured; under Maryland's unique hospital rate-setting system, each hospital patient paid a 6.91% surcharge to cover the cost of uncompensated hospital care for others.[12]

These structural and practical impediments prevent states from enacting effective state-level solutions to the healthcare crisis, a crisis that greatly affects commerce among the several states. Similar problems confronted the states before

[12] Many states with emergency care facilities near other states bear the costs of uncompensated care for citizens of other states, because federal law requires all hospitals receiving Medicare or Medicaid payments (virtually all hospitals) to provide emergency health care to anyone who seeks it, without regard to ability to pay. *See* Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd; *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136-37 (8th Cir. 1996) (en banc).

Congress enacted the Social Security Act; as the Supreme Court observed, the "separate states cannot deal with [the provision of retirement security] effectively" because they "are often lacking in the resources that are necessary to finance an adequate program" and because they may be "reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors." *Helvering v. Davis*, 301 U.S. 619, 644 (1937). A state that offers "such a system is a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose. Only a power that is national can serve the interests of all." *Id.* In the ACA, Congress has made proper use of its power to regulate commerce to serve the interests of all, and has done so in a way that empowers states to address the healthcare crisis in the manner best suited to each state.

II. THE AFFORDABLE CARE ACT SOLVES AN INTERSTATE PROBLEM IN A WAY THAT GIVES GREATER POWER TO THE STATES, BUILDING ON A SUCCESSFUL MODEL OF COOPERATIVE FEDERALISM.

A. The ACA Empowers States to Work With the Federal Government to Better Address Their Healthcare Concerns.

By giving states the flexibility and resources to design and implement their own approaches to healthcare reform, the ACA builds on an established tradition of cooperative federalism, especially in the areas of health care and health insurance. Under a "cooperative federalism" approach, Congress "'leaves to the

States the primary responsibility for developing and executing'" programs, but sets "'requirements to be followed in the discharge of that responsibility.'" *Schaeffer v. Weast*, 546 U.S. 49, 52 (2005) (quoting *Board of Educ. v. Rowley*, 458 U.S. 176, 183 (1982)); *see also Wisconsin Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 495 (2002) (when interpreting statutes "designed to advance cooperative federalism[,] . . . we have not been reluctant to leave a range of permissible choices to the States").

The ACA affords states wide latitude to design approaches to reducing healthcare costs and expanding access to care, and provides states the tools and funding to do so. For instance, the ACA enables states to establish health insurance exchanges in a manner that best meets the needs of their citizens, subject to minimum federal standards, 42 U.S.C. § 18041(b), standards that may be waived if a state wishes to provide access to health insurance in a different way. California, Connecticut, Hawaii, Maryland, Oregon, and Vermont, among other states, have already passed laws setting up health insurance exchanges. 42 U.S.C. § 18052. States may also decline to establish an exchange and instead allow their citizens to access health insurance exchanges operated by the federal government. 42 U.S.C. § 18041(c).

The ACA also affords states flexibility in establishing basic health programs for low-income individuals who are not eligible for Medicaid. States may

implement new coverage programs for individuals and families with incomes between 133% and 200% of the poverty line. 42 U.S.C. § 18051. If a state chooses to implement these programs, its citizens would be able to choose a plan under contract with the state instead of one offered in the insurance exchange. *Id.* The state would receive federal funds to operate the program equal to 95% of the subsidies that would have gone to providing coverage for this group in the exchange. 42 U.S.C. § 18051(d)(3). States may also enter into healthcare choice compacts in which two or more states create such a program. 42 U.S.C. § 18053.

Additionally, the ACA gives states more money to achieve their desired healthcare reforms, both by expanding Medicaid funding and by awarding grants to states developing innovative approaches.[13] The Amici States have already received more than $918 million in grants from the federal government to advance their healthcare priorities.[14] The Urban Institute estimates that, even under the worst-case scenario, the ACA will produce net budgetary savings of $40.6 billion

[13] *See* Stan Dorn & Matthew Buettgens, *Net Effects of the Affordable Care Act on State Budgets* 2 (Urban Institute Report, Dec. 2010).

[14] http://www.healthcare.gov/center/index.html (last accessed August 18, 2011).

for the states between 2014 and 2019.[15] Maryland estimates that it alone will save $853 million over the next ten years as a result of the ACA.[16]

In all of these ways, the ACA encourages states to develop the most effective methods of improving their citizens' access to affordable health care. The federal requirements of minimum coverage and guaranteed issue of insurance to people with preexisting conditions levels the playing field for all states, while protecting against problems of exit and adverse selection.

B. The Affordable Care Act Follows in an Established Tradition of Federal-State Cooperation in the Areas of Health Care and Health Insurance.

Although states have historically regulated standards of health care and the provision of health insurance, the federal government has maintained a presence in the health insurance arena for decades. A prime example is Medicaid, through which the state and federal governments cooperate to extend coverage to children, pregnant mothers, and the disabled who are below the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i). Using federal and state funds, states administer Medicaid and determine, within broad federal guidelines, the benefits that will be

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[15] Dorn & Buettgens, *Net Effects of the Affordable Care Act on State Budgets*, at 2 ("In a best-case scenario, those gains will reach $131.9 billion.").

[16] Testimony of Joshua M. Sharfstein, M.D., Secretary, Maryland Department of Health & Mental Hygiene, before the U.S. Senate Committee on Health, Education, Labor, & Pensions (March 17, 2011).

offered, how much doctors will be paid, and how the program will operate. 42 U.S.C. § 1396a(b).

Congress has regulated extensively in the area of health insurance for several decades. ERISA, enacted in 1974, places limits on the ability of insurance companies to deny coverage. and sets minimum standards for certain aspects of employer-sponsored health insurance. 29 U.S.C. §§ 1181, 1185(a), 1185a. The Consolidated Omnibus Budget Reconciliation Act ("COBRA"), enacted in 1986, requires that employers continue to offer health insurance to employees and their dependents even after the employment relationship has ended. 29 U.S.C. §§ 1161 *et seq*. The Health Insurance Portability and Accountability Act ("HIPAA"), enacted in 1996, sets federal requirements for maintaining the privacy of medical information, 42 U.S.C. §§ 1320d-1 *et seq.*, and further limits the ability of insurers to exclude people with preexisting health conditions, 29 U.S.C. § 1181.

Thus, as an exercise of federal regulatory authority, the ACA does not break new ground, but represents a continuation and expansion of the federal government's presence in an arena in which the states and the national government have long worked cooperatively. Far from invading state sovereignty, the expanded presence of the federal government here gives states *more* power to exercise their sovereign authority to protect their citizens by giving states the tools to reduce costs and expand access to health care.

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

A. The Elements of the ACA Work in Concert to Overcome Barriers to State-Level Solutions to the Healthcare Crisis.

Congress's solution to the nationwide, interstate problems in the healthcare system required a multifaceted approach. In particular, three critical elements of the ACA work in combination to respond to the healthcare crisis in ways that can be effective only if imposed as federal law. First, the ACA expands access to Medicaid, and funds 100% of the cost of that expansion until 2017. 42 U.S.C. § 2001(a). This expansion is projected to increase federal spending on health care for the uninsured, resulting in a dramatic decrease in this burden on states. Because Medicaid is federally funded and jointly administered by the state and federal governments, only Congress can implement regulations that would alter the relative burdens Medicaid imposes on state and federal budgets.

Second, the ACA prohibits insurance companies from refusing to cover individuals with preexisting conditions. 42 U.S.C. § 300gg-3. If implemented by a single state, such a prohibition could attract people with preexisting conditions to that state, leading to higher insurance premiums for all residents and risking the

exit of health insurers from the state.[17] Implementation at the national level, however, does not generate these problems, because no state is more attractive than any other to people with preexisting conditions, and insurers are unlikely to exit the entire national health insurance market, which serves 214 million people.[18]

Third, and at issue in this case, the ACA requires non-exempt persons to maintain "minimum essential coverage" each month through Medicare or Medicaid, an employer-sponsored plan, or a plan offered through a health insurance exchange. 26 U.S.C. § 5000A. The minimum-coverage provision will help reduce the almost $43 billion spent nationally on uncompensated care, 42 U.S.C. § 18091(a)(2)(F), and, as a federal requirement that applies across state lines, it will dramatically reduce healthcare externalities in ways that the states cannot. California will no longer be forced to pay the 5-7% of public hospitals' operating expenses that result from treating uninsured individuals. Maryland hospital patients will be freed from the 6.91% surcharge added to their bills to cover uncompensated care.

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[17] The Privileges and Immunities Clauses of the Constitution limit states' ability to deny benefits to citizens who move from other states to obtain more generous services. *See Saenz v. Roe*, 526 U.S. 489, 498 (1989).

[18] Testimony of Douglas W. Elmendorf, Director, Congressional Budget Office, before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health, Table 3 (March 30, 2011).

Each of these three elements of the ACA is needed in order for the others to be effective. Taken together, there can be no doubt that they regulate commerce among the several states. *See Thomas More Law Ctr. v. Obama*, No. 10-2388, 2011 U.S. App. LEXIS 13265, at *38 (6th Cir. June 29, 2011) (Martin, J.).

B. The Minimum–Coverage Provision Is an Essential and Lawful Component of the ACA.

The minimum-coverage provision is an essential and lawful part of the ACA's attempt to provide healthcare access to individuals with preexisting conditions, a group that is among the hardest of the uninsured to cover. The provision is essential because it helps prevent individuals from free riding on state and federal budgets and on those who responsibly obtain health insurance. It is also essential because, without it, the preexisting-condition prohibition would lead to much higher insurance premiums, causing more people to forgo health insurance, thereby worsening the impact on state and federal budgets.

The increase in insurance premiums without a minimum-coverage requirement is due to the phenomenon of moral hazard: Under a system where health insurers cannot turn away people with preexisting conditions, many people will simply wait to purchase insurance until they are facing a health emergency, secure in the knowledge that they will be able to obtain insurance for expensive treatments when the time comes. This manifestation of moral hazard, known as

adverse selection, skews the insurance pool, since people will tend to opt into the pool only when they perceive their health risks to be great.

The problem of adverse selection is exacerbated by two distinct features of the healthcare market: the need for services is highly unpredictable, and the cost of those services can be ruinously expensive.[19] One's health condition, of course, is not static. There is no class of healthcare consumers who are forever impervious to illness and injury. Rather, presently healthy people (almost ineluctably) become unhealthy or injured in the future and then require more costly treatment, just as presently unhealthy people regain their health and then require less costly treatment. No insurance regime can survive if people can opt out when the risk insured against is only a risk, but opt in when the risk materializes. Congress enacted the minimum-coverage provision to prevent free riders from distorting market prices for insurance in this way.[20]

The minimum-coverage provision is justified under the Commerce Clause as "an essential part of a larger regulation" of the health insurance industry. *United States v. Lopez*, 514 U.S. 549, 561 (1995). As the Supreme Court recognized in *Raich*, Congress has the "power to regulate purely local activities that are part of an economic class of activities that have a substantial effect on interstate

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

[20] *See* Siegel, *Free Riding on Benevolence*, at 25-27.

commerce." *Raich*, 545 U.S. at 17 (internal quotations and citations omitted). "'[E]ven if [the regulated] activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce.'" *Id.* at 18 (quoting *Wickard*, 317 U.S. at 124); *United States v. Howell*, 552 F.3d 709, 714 (8th Cir. 2009); *Hanf v. United States*, 235 F.2d 710, 718 (8th Cir. 1956) ("Where activities in intrastate commerce substantially affect interstate commerce so as to make its control difficult, Congress then has the power to regulate such intrastate activities.").

The "economic class of activities" at issue here is the consumption of health care and corresponding decisions regarding payment for that health care—activities that plainly exert a substantial economic effect on interstate commerce. As Congress found, "[t]he cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008." 42 U.S.C. § 18091(a)(2)(F). Cost-shifting from care for the uninsured inflates family health insurance premiums "by on average over $1,000 a year." *Id*; *see Thomas More*, 2011 U.S. App. LEXIS 13265, at *73 (Sutton, J., concurring) ("No matter how you slice the relevant market—as obtaining health care, as paying for health care, as insuring for health care—all of these activities affect interstate commerce, in a substantial way.").

As the Court in *Raich* observed, "[w]hen Congress decides that the 'total incidence' of a practice poses a threat to a national market, it may regulate the

entire class." *Raich*, 545 U.S. at 17. Here the total incidence of the practice of forgoing health insurance and then consuming health care, leading to billions of dollars spent on uncompensated care, poses a serious threat to the national market for health care and health insurance. Its regulation is therefore lawful and appropriate under the Commerce Clause. *See Thomas More*, 2011 U.S. App. LEXIS 13265, at *38 (Martin, J.).

C. The Minimum-Coverage Provision Regulates Activity.

The plaintiffs argue that, regardless of its effects, forgoing the purchase of health insurance is not an "activity," and therefore, supposedly, beyond Congress's reach under the Commerce Clause. As an initial matter, the "activity"/"inactivity" distinction is irrelevant, and has no basis in Commerce Clause jurisprudence. *See Thomas More*, 2011 U.S. App. LEXIS 13265, at *44 ("[T]he text of the Commerce Clause does not acknowledge a constitutional distinction between activity and inactivity, and neither does the Supreme Court.") (Martin, J.); *see also id.* at *81 (Sutton, J., concurring) (the Commerce Clause does not "contain an action/inaction dichotomy that limits congressional power"); *Carter v. Carter Coal Co.*, 298 U.S. 238, 307-308 (1936) (Commerce Clause permits regulation of any "activity *or condition*" that substantially affects interstate commerce (emphasis added)); *Spain v. St. Louis & S.F.R. Co.*, 151 F. 522, 523, 525 (C.C.E.D. Ark. 1907) (the term 'interstate commerce' "comprehend[s] intercourse for the purposes of trade in any

and all its forms" (citation omitted)). As Justice Scalia has observed, "[e]ven as a legislative matter . . . the intelligent line does not fall between action and inaction." *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296 (1990) (Scalia, J., concurring).

The irrelevance of the supposed "activity"/"inactivity" distinction is evidenced in *Wickard*, where the Court found that a decision to "forestall resort to the market" for wheat—like a decision to forestall resort to the health insurance market—constituted an activity that, in the aggregate, substantially affected a national market. 317 U.S. at 127-28. Similarly, in *Raich*, the Court found that growing or possessing marijuana for one's own use—without any consumption, trade, or other "activity" related to it—is subject to federal regulation, where Congress had a rational basis for believing that, when viewed in the aggregate, that conduct would affect price and market conditions. *See* 545 U.S. at 19; *see also United States v. Mugan*, 441 F.3d 622, 629-30 (8th Cir. 2006) (mere intrastate possession of child pornography, prior to any interstate trade related to it, "is an economic activity connected to interstate commerce" and therefore subject to federal regulation).

Regardless, forgoing health insurance is indeed an activity. As the Sixth Circuit has explained, "[F]ar from regulating inactivity, the minimum coverage provision regulates individuals who are, in the aggregate, active in the health care

market." *Thomas More*, 2011 U.S. App. LEXIS 13265, at *46-*47 (Martin, J.); *see also id.* at *85 (Sutton, J., concurring) ("No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk. Each requires affirmative choices; one is no less active than the other; and both affect commerce."). If it is "inactivity" to forgo health insurance, when the United States expends more than $43 billion annually to cover the cost of care for those without insurance, then there's a whole lot of "inactivity" going on in the national healthcare market.

D. The Minimum-Coverage Provision Is a Necessary and Proper Means to Regulate the Health Insurance Market.

Congress's authority under Article I, Section 8 of the Constitution to "make all laws which shall be necessary and proper for carrying into execution" Congress's enumerated powers further confirms the validity of the minimum-coverage provision. Requiring people to carry "minimum essential coverage" is a necessary and proper component of the ACA that is needed to carry into execution the ACA's regulation of the interstate healthcare and healthcare-financing market. The Necessary and Proper Clause authorizes Congress to "regulate even those intrastate activities that do not substantially affect interstate commerce" as well as "noneconomic local activity" where necessary to make a regulation of interstate commerce effective. *Raich*, 545 U.S. at 35, 37 (Scalia, J., concurring); *United*

States v. Wrightwood Dairy Co., 315 U.S. 110, 118–19 (1942) (under the Necessary and Proper Clause, Congress "possesses every power needed to make [its] regulation effective"); *Howell*, 552 F.3d at 714 (power includes the "ability to regulate intrastate, noneconomic activity that does not have a substantial effect on interstate commerce").

The minimum-coverage provision is essential to the success of the reforms that prohibit insurers from denying coverage or setting premiums based on preexisting conditions. 42 U.S.C. § 18091(a)(2)(I); *Thomas More*, 2011 U.S. App. LEXIS 13265, at *44 (Martin, J.) ("Congress had a rational basis for concluding that the minimum coverage requirement is essential to its broader reforms to the national markets in health care delivery and health insurance."). Thus, "even if self-insuring for the cost of health care were not economic activity" that substantially affects interstate commerce—in fact, it is and it does—Congress "could still properly regulate the practice because the failure to do so would undercut its regulation of the larger interstate markets in health care delivery and health insurance," *id.* at *38, including the ACA regulations aimed at lowering the cost of health insurance and prohibiting the denial of coverage based on preexisting conditions.

The appropriate inquiry under the Necessary and Proper Clause is whether "the means chosen are 'reasonably adapted' to the attainment of a legitimate end

under the commerce power." *United States v. Comstock*, 130 S. Ct. 1949, 1957 (2010); *accord United States v. Tom*, 565 F.3d 497, 502 (8th Cir. 2009); *Howell*, 552 F.3d at 714. Reducing the expense of health care and expanding access to health insurance is indisputably a "legitimate end under the commerce clause" and the minimum-coverage provision is a means "reasonably adapted" to this legitimate end.

The minimum-coverage provision is a necessary and beneficial component of healthcare reform legislation that regulates commerce to address problems in an interstate market that the states could not solve alone. The legislation embraces constitutional principles of cooperative federalism by instituting policy innovations that will be implemented through the joint participation of the state and federal governments. The ACA neither exceeds Congress's powers nor intrudes on the states' powers. It is constitutional.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(a) of the Federal Rules of Appellate Procedure, I hereby certify that the textual portion of the foregoing brief (exclusive of the tables of contents and authorities, certificate of service and compliance, but including footnotes) contains 6,998 words as determined by the word-counting feature of Microsoft Word 2010. The font used is Times New Roman at 14-point type.

I also certify that the Brief has been scanned for viruses and is virus-free.

/s/ Stephen M. Ruckman
Stephen M. Ruckman

August 18, 2011

CERTIFICATE OF SERVICE

Pursuant to Rule 25 of the Federal Rules of Appellate Procedure, I hereby certify that, on August 18, 2011, I electronically filed the foregoing with the Clerk of the Court for the U.S. Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

/s/ Stephen M. Ruckman
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