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No. 10-2388

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

THOMAS MORE LAW CENTER, ET AL.,
Plaintiffs-Appellants,

v.

BARACK HUSSEIN OBAMA, ET AL.,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN

BRIEF OF AMICI CURIAE AMERICAN NURSES ASSOCIATION; AMERICAN ACADEMY OF PEDIATRICS; AMERICAN MEDICAL STUDENT ASSOCIATION; CENTER FOR AMERICAN PROGRESS D/B/A DOCTORS FOR AMERICA; NATIONAL HISPANIC MEDICAL ASSOCATION; AND NATIONAL PHYSICIANS ALLIANCE IN SUPPORT OF APPELLEES AND AFFIRMANCE

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit Case Number: 10-2388   Case Name: Thomas More Law Center v. Obama

Name of counsel: Ian R. Millhiser

Pursuant to 6th Cir. R. 26.1, American Academy of Pediatrics, et al.
Name of Party
makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

None of the amici joining this brief are a subsidiary or affiliate of a publicly owned corporation.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

No.

CERTIFICATE OF SERVICE

I certify that on January 21, 2011 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

s/ Ian Millhiser

This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

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Interests of the *Amicus Curiae*[1]

Amici are diverse health care provider organizations representing millions of doctors, nurses and other health care professionals throughout the country. *Amici* believe that the Affordable Care Act is a significant achievement for the patients that their members serve because it ensures greater protection against losing or being denied health insurance coverage and it promotes better access to primary care and to wellness and prevention programs. The Act's goal of optimizing health insurance coverage for the greatest number of people permits healthcare professionals to place their attention on the most important thing—the patient's well-being and healing—rather than on economic considerations.

Amici have a significant interest in assisting the Court in understanding that the minimum coverage provision challenged by plaintiffs is essential to the Affordable Care Act's provisions ensuring that health insurance is both universally available and affordable. Because *amici*'s members work on the front lines of the health care system, they know from

[1] This brief is filed with the consent of the parties pursuant to Federal Rule of Appellate Procedure 29(a). Pursuant to Federal Rule of Appellate Procedure 29(c)(5), 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.

experience that patients who put off needed care due to lack of insurance often end up sicker and require much costlier emergency room care. Moreover, *amici*'s members work throughout the continuum of care and in all settings within the health care industry—from direct care to hospital administration. As a result, *amici* have a uniquely broad perspective on the impact of the Affordable Care Act and the capacity to offer information that can guide the court's understanding of the consequences of removing the minimum coverage provision to the health provider, patients, and insurance markets as a whole.

ARGUMENT

Congress enacted the Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010) ("ACA") to achieve near-universal health insurance coverage, significantly reduce the economic costs of poor outcomes among presently uninsured Americans, prevent cost shifting from uninsured Americans receiving uncompensated care to Americans with insurance, and improve the financial security of all families against medical costs. § 10106(a). Yet, as Congress determined in enacting the ACA, the reforms enacted to achieve these goals cannot function effectively without a provision requiring all Americans who can afford insurance to either obtain

it or pay an additional portion of their income with their annual tax return.[2] § 1501(a)(2)(G). Because Congress possesses the constitutional authority to prevent a comprehensive economic regulatory scheme from being so undermined, the minimum coverage provision should be upheld. *See Gonzales v. Raich*, 545 U.S. 1, 22 (2005) (holding that courts should "refuse to excise individual components" of a larger regulatory scheme even when those components could not be enacted on their own under the Commerce Clause).

A. The Necessary and Proper Clause Empowers Congress to Enact Provisions That Are Reasonably Adapted To Making A Broader Regulatory Scheme Effective

"[T]he Necessary and Proper Clause makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive'" to an enumerated power's "beneficial exercise." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 413, 418 (1819)). Moreover, "Chief Justice Marshall emphasized that the word 'necessary' does not mean 'absolutely necessary.'" *Id.* Rather, "[I]n determining whether the

[2] The ACA labels this provision the "Requirement to Maintain Minimum Essential Coverage." § 1501. The provision is referred to as the "minimum coverage provision" throughout this brief.

Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, [courts] look to see whether the statute constitutes a means that is *rationally related* to the implementation of a constitutionally enumerated power." *United States v. Belfast*, 611 F.3d 783, 805 (11th Cir. 2010) ((quoting *Comstock*, 130 S.Ct. at 1956) (emphasis in original)).

Plaintiffs attempt to draw a distinction between laws regulating "activity" and laws supposedly regulating "inactivity" under the Necessary and Proper Clause, claiming that the ACA's minimum coverage provision is flawed because it regulates a failure to act in the health care market. Significantly, plaintiffs are unable to cite a single case interpreting the Necessary and Proper Clause which supports this novel, extra-constitutional distinction—and no such case exists.[3] As Justice Scalia explains, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses *every power* needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118 (1942)) (emphasis added).

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[3] Moreover, plaintiffs' claim that uninsured patients do not participate in the health care market reflects a flawed understanding of that market. *See generally* Brief of *Amici Curiae* Economic Scholars.

Amici acknowledge that, while Congress' Necessary and Proper power is very broad, it is not without limits. When invoked as part of a comprehensive economic regulatory scheme, the Necessary and Proper power "can only be exercised in conjunction with congressional regulation of an interstate market, and it extends only to those measures necessary to make interstate regulation effective." *Id.* at 38 (Scalia, J, concurring in the judgment). These conditions are met in this case, as the minimum coverage provision is necessary to make the related insurance reforms effective. When Congress enacts a unique regulatory scheme or regulates a unique market under its Commerce Power, the very uniqueness of such a law may bring new regulatory tools within the Necessary and Proper Clause's umbrella.

The Necessary and Proper Clause also empowers Congress to ensure that federal monies are not spent wastefully. In *Sabri v. United States*, 541 U.S. 600 (2004), the Supreme Court upheld a wide-reaching statute criminalizing bribery of any state official whose agency or government receives federal funds, even though the statute swept broadly to include officials who have no contact with the federal funds. As the Court explained, "Congress has authority under the Spending Clause to appropriate federal monies to promote the general welfare, and it has corresponding

authority under the Necessary and Proper Clause to see to it that taxpayer dollars" are not "frittered away" by bribery-motivated projects that are not cost-effective. *Id.* at 605 (citations omitted).

B. The Minimum Coverage Provision is "Reasonably Adapted" To Congress' Legitimate Ends Of Regulating Interstate Commerce in the Health Market and Ensuring that Federal Health Care Spending is Not Wasted

To accomplish its goals of improving health outcomes, extending insurance coverage and promoting financial security against health costs, the ACA creates an interconnected network of subsidies and regulations. Most notably, the Act prohibits insurers from denying coverage to consumers with preexisting conditions or charging them higher premiums, ACA § 2704, and it provides tax subsidies for insurance coverage to individuals with incomes between 133% and 400% of the poverty line. § 1401–02, 2001. Without the minimum coverage provision, these two provisions will be severely undermined. Rather than ensuring equal access to insurance for Americans with disabilities or preexisting conditions, the ACA's preexisting conditions provision would threaten the nationwide individual insurance market if it does not take effect in conjunction with a minimum coverage provision. Likewise, the generous subsidies offered by the ACA will diminish drastically in value absent a minimum coverage provision.

1. Removing The Minimum Coverage Provision Would Drive Up The Costs of Care For The Uninsured and Shift These Costs To Persons With Insurance

Many health conditions and illnesses, if caught early and treated with appropriate follow-up care, can be relatively inexpensive to resolve. Many conditions can be avoided altogether through preventive care. Yet if these conditions or illnesses do not receive prompt and appropriate treatment, they can often require hospitalization or otherwise deteriorate into a serious condition requiring expensive care. *See* Institute of Medicine, Health Insurance is a Family Matter 106 (2002). Because federal law requires virtually all emergency rooms to stabilize patients regardless of their ability to pay, *see* Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd., the cost of this expensive care winds up being transferred to patients with insurance or to government programs such as Medicare or Medicaid. Accordingly the minimum coverage provision is reasonably adapted to ensuring that government health care spending is not "frittered away" on preventable health care costs. *Sabri*, 541 U.S. at 605.

The likelihood that a patient will receive adequate preventive care or early treatment is directly related to whether the patient is insured. One study determined that children enrolled in a public health insurance plan were 15 percentage points more likely to receive preventive care than those

who were not. Institute of Medicine, America's Uninsured Crisis: Consequences for Health and Health Care 61 (February 2009) ("Uninsured Crisis"). Likewise, multiple studies found that uninsured children are "less likely to be up-to-date on their immunizations than insured children, controlling for observed characteristics of the children." *Id.* Use of dental services also increases between 16 and 40 percentage points among children who are insured. *Id.* at 62.

The data for adult patients is ever starker:

> [C]hronically ill adults who lacked health insurance had five to nine fewer health care visits per year than chronically ill adults who have health insurance. Uninsured adults with chronic illnesses were much more likely than their insured peers to go without any medical visits during the year—even when they were diagnosed with serious conditions such as asthma (23.4 of uninsured adults with no visits vs. 6.2 percent of insured adults), COPD (13.2 vs. 4.0 percent), depression (19.3 vs. 5.2 percent), diabetes (11.0 vs. 5.2 percent), heart disease (8.7 vs. 2.9 percent), or hypertension (12.7 vs. 5.3 percent).
>
> Similarly, uninsured adults with asthma, cancer, COPD, diabetes, heart disease, or hypertension are at least twice as likely as their insured peers to say that they were unable to receive or had to delay receiving a needed prescription[.]

Id. at 65. Likewise, routine preventive care such as "mammography, Pap testing, cholesterol testing, and influenza vaccination" is far less common among adults who experience frequent periods of uninsurance. *Id.* While women who are consistently insured have a 76.7 percent chance of receiving

mammographies, that chance declines to 34.7 percent for women who experience frequent periods of uninsurance. *Id.* Uninsured adults are also much less likely to have a continuing relationship with a single provider. Among uninsured adults, "19 percent with heart disease, 14 percent with hypertension, and 26 percent with arthritis do not have a regular source of care, compared with 8, 4, and 7 percent, respectively, of their insured counterparts." Institute of Medicine, Care Without Coverage: Too Little, Too Late 29 (2002) ("Care Without Coverage"). This disparity is troubling because patients with chronic conditions often must "modify[] their behavior, monitor[] their condition and participat[e] in treatment regimens" in order to keep their condition under control. *Id.* at 57. Such tasks require patients to develop a complex understanding of their condition and to master tasks that do not come naturally to persons without education or training in the health sciences. Thus, a patient's continuing relationship with a single provider who can answer their questions and monitor their care is "a key to high-quality health care" for persons with chronic conditions. *Id.*

There is robust data demonstrating that uninsured patients' diminished access to care causes their medical conditions to deteriorate. One study found that "near-elderly adults who lost their insurance were subsequently 82 percent more likely than those who kept their private insurance to report a

decline in overall health." J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 Milbank Q. 443, 469 (2009) ("Uninsurance Among Adults"). The rate of asthma-related hospital stays for children with asthma in New York dropped from 11.1 percent to 3.4 percent when those children were enrolled in a state insurance program. Peter G. Szilagyi, et al., *Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York*, 117 Pediatrics 486, 491 (2006). Uninsured children diagnosed with diabetes are "more likely to present with severe and life-threatening diabetic ketoacidosis" than insured children with the same condition. Uninsured Crisis at 71. Among stroke patients, "[t]he mortality risk of uninsured patients was 24% to 56% higher than that of their privately insured peers for acute hemorrhagic and acute ischemic stroke, respectively." Jay J. Shen and Elmer L. Washington, *Disparities in Outcomes Among Patients With Stroke Associated With Insurance Status*, 38 Stroke 1010, 1013 (2007). Likewise, "5-year survival rates for uninsured adults were significantly lower than for privately insured adults diagnosed with breast or colorectal cancer—two prevalent cancers for which there are not only effective screening tests, but also treatments demonstrated to improve survival." Uninsured Crisis at 78. Indeed, a recent Institute of

Medicine report documented dozens of empirical studies linking uninsurance with poor health outcomes and deteriorated medical conditions. *See generally* Uninsured Crisis.

When uninsured patients fail to receive preventive care, continuing care or early treatment, their healthcare needs and the cost of meeting those needs still require them to participate in the health care market. As a condition of their hospital's participation in Medicare, hospital emergency departments must stabilize any patent who seeks treatment for an emergency medical condition regardless of the patient's ability to pay. *See* Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd. Thus, an uninsured patient whose condition deteriorates because they are unable to afford less expensive preventive or early care will nonetheless receive expensive emergency treatment for that condition. *See* Care Without Coverage at 58 (indicating that many uninsured patients "identify an emergency department as their regular source of care"). The cost of this uncompensated care is then distributed to other patients or to government health programs such as Medicare or Medicaid. According to one study, this cost shifting adds, on average, $410 to each individual insurance premium and $1,100 to each family premium. Ben Furnas & Peter Harbage, Ctr. for Am. Progress, *The Cost-Shift from the Uninsured* 2 (March 24, 2009) ("Cost-Shift").

Uninsured patients' likelihood to delay care and the subsequent deterioration of health also drive up Medicare costs. A twelve-year study of patients approaching the age of Medicare eligibility found that previously uninsured patients with cardiovascular disease (hypertension, heart disease, or stroke) or diabetes often did not receive widely-available and effective treatments to prevent costly complications if their conditions developed before they qualified for Medicare. As a result, "previously uninsured Medicare beneficiaries with these conditions reported 13 percent more doctor visits, 20 percent more hospitalizations, and 51 percent more total medical expenditures" than similarly situated patients who were insured prior to qualifying for Medicare. Uninsurance Among Adults at 468.

Congress may, through the valid exercise of its spending power, require Medicare hospitals to accept uninsured patients into their emergency rooms as a condition of participation in the Medicare program. The ACA's minimum coverage provision is reasonably adapted to preventing this requirement from driving up the cost of Medicare to taxpayers and increasing the cost of insurance for individual and families receiving subsidies under the ACA. Accordingly, this provision should be upheld under Congress' Necessary and Proper power. *See Comstock*, 130 S. Ct. at

1957; *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment)); *Sabri*, 541 U.S. at 604–08.

2. Removing the Minimum Coverage Provision Drastically Reduces the Value of the ACA's Subsidies And Imperils the National Insurance Market

Adverse selection occurs when an individual "wait[s] to purchase health insurance until they need[] care," thus enabling them to receive benefits from an insurance plan that they have not previously contributed to. ACA § 10106(a). The consequences of adverse selection is an insurance "death spiral" which can eventually collapse an insurance market. *See* Thomas R. McLean, *International Law, Telemedicine & Health Insurance: China as a Case Study*, 32 Am. J. L. and Med. 7, 21 (2006) ("[A]dverse selection removes good-risk patients from the market, resulting in the need for insurers to raise their premiums; which triggers another round of adverse selection.")

Insurers typically defend against adverse selection by screening potential customers with disabilities or preexisting conditions, but the ACA specifically forbids this practice. § 2704. Thus, the ACA requires most currently healthy Americans to participate in the insurance market to prevent them from strategically avoiding that market until they become ill or injured. § 10106(a) ("[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 preexisting conditions can be sold.")

Because of this adverse selection problem, the Congressional Budget Office estimates that premiums will increase drastically absent a minimum coverage provision:

> CBO and [the Joint Committee on Taxation] estimate that, relative to current law, the elimination of the mandate would reduce insurance coverage among healthier people to a greater degree than it would reduce coverage among less healthy people. As a result, in the absence of a mandate, those who enroll would be less healthy, on average, than those enrolled with a mandate. *This adverse selection would increase premiums for new non-group policies (purchased either in the exchanges or directly from insurers in the non-group market) by an estimated 15 to 20 percent relative to current law.* Without the mandate, Medicaid enrollees would also have higher expected health spending, on average, than those enrolled under current law.

Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010) ("Effects of Eliminating") (emphasis added); *see also* Jonathan Gruber, Ctr. for Am. Progress, *Health Care Reform is a 'Three-Legged Stool* 1 (Aug. 5, 2010) (estimating that the average premium for a non-group health insurance plan would increase 27% by 2019 if the ACA goes into effect without a minimum coverage provision).

If anything, this CBO estimate greatly underestimates the cost of excising the minimum coverage provision. States which required insurers to cover individuals with preexisting conditions but did not enact a minimum coverage provision experienced far more drastic consequences than the premium spikes CBO predicts. Kentucky, Maine, New Hampshire and Washington each lost most or all of their individual market insurers after those states enacted a preexisting conditions provision without enacting a minimum coverage provision, and the cost of some New Jersey health plans more than tripled after that state enacted a similar law. *See* Vickie Yates Brown, et al., *Health Care Reform in Kentucky - Setting the Stage for the Twenty-First Century?*, 27 N. Ky. L. Rev. 319, 330 (2000) ("Health Care Reform in Kentucky"); Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. of Health Politics, Pol'y and L. 133, 140, 152 (2000) ("Riding the Bull"); Maine Bureau of Insurance, *White Paper: Maine's Individual Health Insurance Market* 5, 8, (January 22, 2001) ("Maine's Individual Health Insurance Market"), Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 Health Affairs 167, 169–70 (2004).

As the experience of these states and the weight of economic evidence demonstrates, the minimum coverage provision is necessary to prevent the preexisting conditions provision from creating a fatal adverse selection spiral—and this is sufficient reason to uphold the minimum coverage provision under the Necessary and Proper Clause. *See Comstock*, 130 S.Ct. at 1956.

Additionally, removing the minimum coverage provision would, in the words of *Sabri*, "fritter[] away" literally hundreds of billions of "taxpayer dollars." 541 U.S. at 605. The Congressional Budget Office determined that eliminating the minimum coverage provision would increase the federal deficit by $252 billion between 2014 and 2020, with approximately 60 percent of this additional debt stemming from increased health care costs. Effects of Eliminating at 1. Yet while the federal government would spend hundreds of billions more without a minimum coverage provision, the nation would receive far less for its investment, as excising the minimum coverage provision "would increase the number of uninsured by about 16 million people, resulting in an estimated 39 million uninsured in 2019." *Id.* at 2.

Because the minimum coverage provision is both necessary to ensure that the preexisting conditions provision is effective and essential to prevent

hundreds of billions of dollars from being "frittered away," it falls comfortably within Congress' Necessary and Proper power.

3. A Decision Upholding the Minimum Coverage Provision Would Not Justify the Hypothetical Federal Health Care Laws Suggested By Plaintiffs

Plaintiffs claim that if the minimum coverage provision is upheld, "the federal government could mandate that we all join a health club and indeed impose on us a penalty for not actually attending the club, to take multi-vitamins daily, and to dine only in government-approved "health" restaurants." Appellant's Br. at 12. This claim, however, ignores the unique nature of the health insurance market.

As explained above, the health insurance market faces a unique "cost shifting" problem, which causes prices in the health care market to behave in a counterintuitive manner. *See* Cost-Shifting at 2 (explaining that uncompensated care provided to the uninsured adds $410 to each individual insurance premium and $1,100 to each family premium). The laws of supply and demand dictate that a law that increased the number of people purchasing vitamins would also drive up the costs those vitamins. Likewise, a law adding more consumers to a health club's membership rolls would drive up the cost of such memberships. Health insurance, by contrast, becomes more affordable when it is more widely purchased. *Id.*

Similarly, the national market for health clubs is not in danger of collapsing if Congress does not require people to join these clubs. Nor is there a risk that Americans will cease to be able to obtain multi-vitamins absent a law requiring the purchase of health supplements. The nation's individual health insurance market, by contrast, is susceptible to complete collapse if people can wait until they are ill or injured to buy insurance. *See* Riding the Bull at 140 & 152 (describing the catastrophic consequences of enacting a preexisting conditions law without a minimum coverage provision in Kentucky and Washington); Maine's Individual Health Insurance Market at 5 & 8 (describing same in Maine and New Hampshire).

More importantly, there is no federal law which depends upon mandatory health club membership or mandatory vitamin purchases in order to function properly in the same way that the ACA's preexisting conditions provision can only function properly in the presence of a minimum coverage provision. Accordingly, the Necessary and Proper Clause does not provide a constitutional basis for plaintiff's hypothetical health care laws in the same way that it supports the minimum coverage provision. *See Raich*, 545 U.S. at 38 (Scalia, J., concurring in the judgment) ("[T]he power to enact laws enabling effective regulation of interstate commerce can only be exercised in conjunction with congressional regulation of an interstate market, and *it*

extends only to those measures necessary to make the interstate regulation effective." (emphasis added)).

CONCLUSION

For the foregoing reasons, *amici* respectfully submit that the Court should **AFFIRM** the decision of the district court.

Dated: January 21, 2010

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(a)(7)(B)

I hereby certify that this brief complies with the type-face and volume limitations set forth in Federal Rule of Appellate Procedure 32(a)(7)(B). The type face is fourteen-point Times New Roman font, and the number of words is 3,866.

/s/ Ian Millhiser

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. All counsel of record are registered CM/ECF users.

/s/ Ian Millhiser