No. 11-398

IN THE

Supreme Court of the United States

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

v.

FLORIDA, *et al.*,
Respondents.

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

BRIEF OF *AMICUS CURIAE* THE CALIFORNIA ENDOWMENT IN SUPPORT OF PETITIONERS AND IN FAVOR OF REVERSAL ON THE MINIMUM COVERAGE PROVISION

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INTEREST OF *AMICUS CURIAE*[1]

The California Endowment ("TCE") has an important interest in the constitutionality of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).[2] TCE is a private foundation committed to the expansion of affordable, quality health care for all Californians, particularly those in underserved and low income communities. As part of this goal, TCE sponsors a variety of social science and public policy research in an effort to show both policymakers and health care consumers the benefits of expanding the scope of health insurance.

TCE supports the implementation of the ACA, a comprehensive, multifaceted legislative scheme aimed at achieving near-universal and affordable health care coverage for every American citizen. Petitioners' Brief ("Pet'rs Br.") 9-12. A cornerstone of the Act is its reform of market failures in the health care delivery system resulting from the fact that 50 million Americans lack health insurance. The ACA

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[1] Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amicus curiae* and its counsel, made any monetary contribution toward the preparation or submission of this brief. On November 15, 16, and 22, 2011, all parties filed letters with the Clerk of Court reflecting their blanket consent to the filing of *amicus* briefs.

[2] As amended by the Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

addresses these market failures in the health care delivery system by requiring uninsured persons to purchase basic health insurance to cover their care. This minimum coverage requirement ("MCR"), 26 U.S.C. § 5000A, will reduce the amount of uncompensated care and expand the insurance risk pool, thereby lowering insurance premiums overall. *See* 42 U.S.C. § 18091(a)(2)(I).

TCE submits this brief to provide the Court with additional justifications and empirical support for Petitioners' arguments that the MCR is within Congress's powers under the Commerce Clause and the Necessary and Proper Clause. TCE believes that the Eleventh Circuit's decision in *Florida v. United States Department of Health & Human Services*, 648 F.3d 1235 (11th Cir. 2011), if left intact, would deny Congress the power to use the most effective means available to correct heretofore intractable problems in the efficient delivery and distribution of health care services.

SUMMARY OF ARGUMENT

In enacting the ACA, Congress recognized that one of the key drivers of spiraling health care expenditures is the uncompensated medical costs of uninsured persons, totaling $43 billion in 2008. 42 U.S.C. § 18091(a)(2)(F). Such "uncompensated care," *id.*, results from the fact that individuals who lack health insurance regularly consume health care services they cannot afford. The costs of such care are transferred throughout the interstate economy through private insurers, who raise insured individuals' premiums, creating an ongoing "free-rider" problem. *Id.* Nor can the problem be solved simply by allowing anyone to purchase insurance at any time: doing so

creates an "adverse selection" problem whereby only those individuals who are currently ill newly purchase insurance, again driving up health insurance premiums for all. *See id.* § 18091(a)(2)(I).

Congress sought to correct these market failures in the health care delivery system by enacting the MCR, the crucial feature of the ACA that requires uninsured persons to purchase basic health insurance to cover their care. Evidence from the State of California provides particularly strong confirmation of Congress's judgment that the MCR will reduce the amount of uncompensated care and expand the insurance risk pool, thereby lowering insurance premiums overall. In California alone, one recent TCE-sponsored study shows, the MCR will expand the pool of the newly insured by nearly 2 million California citizens, while without the MCR, that number drops by more than 50 percent.

The MCR is well within Congress's authority under the Commerce Clause. While Congress's powers under the Commerce Clause are not unlimited, *see United States v. Morrison*, 529 U.S. 598, 608 (2000); *United States v. Lopez*, 514 U.S. 549, 557 (1995), this Court has reaffirmed that Congress has broad authority to regulate even seemingly intrastate economic activities that, "viewed in the aggregate, substantially affect[ ] interstate commerce," *id.* at 561, especially where it does so as part of a comprehensive regulatory scheme, *see Gonzalez v. Raich*, 545 U.S. 1, 25 (2005).

The ACA's regulation of the distribution, purchase, and consumption of health services—economic activities that devour 17.6 percent of GDP, 42 U.S.C. § 18091(a)(2)(B)—falls squarely within Commerce Clause authority. And recent national and Califor-

nia-specific data support Congress's finding that the MCR is an essential part of that overall regulatory scheme. Specifically, the MCR is a uniquely effective means of remedying the failures in the interstate market for health services that Congress identified in the ACA. This data provides a "demonstrated link in fact, based on empirical demonstration" that there is "a tangible link to commerce, not a mere conceivable rational relation." *United States v. Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring in the judgment) (describing the standard of review for Congress's exercise of authority under the Commerce Clause).

Moreover, the MCR falls within Congress's powers under the Necessary and Proper Clause to "enact laws in effectuation of its enumerated powers that are not within its authority to enact in isolation." *Raich*, 545 U.S. at 39 (Scalia, J., concurring in the judgment) (citing *McCulloch v. Maryland*, 17 U.S. (4 Wheat) 316, 421-22 (1819)); *accord Comstock*, 130 S. Ct. at 1956-57. Because the MCR is an "essential part of a larger regulation of economic activity," *Raich*, 545 U.S. at 24, it is a fully justified exercise of Congress's powers. Specifically, the MCR is a core component of Congress's broader reform efforts to require insurers to accept all applicants regardless of health conditions, thus expanding access to health care while simultaneously lowering health care costs. *See* 42 U.S.C. § 18091(a)(2)(C), (E), (I).

Because the Eleventh Circuit provided no tenable basis to invalidate Congress's effort to address identified market failures substantially burdening interstate commerce, the decision below should be reversed.

ARGUMENT

I. THE MINIMUM COVERAGE REQUIREMENT FALLS WELL WITHIN CONGRESS'S COMMERCE CLAUSE AUTHORITY

Nearly 50 million Americans lack health insurance,[3] resulting in "uncompensated care" of uninsured persons in the Nation's medical and health care system that totaled $43 billion in 2008. 42 U.S.C. § 18091(a)(2)(F). When individuals who lack health insurance regularly consume health care services they cannot afford, the costs of their care are transferred to others as private insurers raise insured individuals' premiums. This "free-rider" problem cannot be solved by allowing anyone to purchase insurance at any time. Allowing uninsured individuals to wait until they are ill or injured before buying health insurance creates an "adverse selection" problem, driving up health insurance premiums for all. *See id.* § 18091(a)(2)(I).

In enacting the ACA, Congress appropriately recognized the need to address these market failures in the health care delivery system. A cornerstone of that law is the MCR, which requires uninsured persons to purchase basic health insurance to cover their care. Congress expressly found in enacting the ACA that the MCR would serve its goals of reducing the amount of uncompensated care and expanding the insurance risk pool, thereby lowering insurance premiums overall. *See id.*

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[3] *See* Danilo Trisi *et al.*, *Poverty Rate Second-Highest in 45 Years; Record Numbers Lacked Health Insurance, Lived in Deep Poverty*, CENTER ON BUDGET AND POLICY PRIORITIES (Sept. 14, 2011), http://www.cbpp.org/cms/index.cfm?fa=view&id=3580.

Recent TCE-sponsored empirical research confirms these congressional findings. Specifically, this empirical data demonstrates that the MCR will achieve significant results: in California alone, the absence of the MCR would reduce the number of newly insured California citizens by 54 percent in 2019, such that 1 million fewer Californians will have health insurance.[4] With the MCR, the ACA would expand the pool of newly insured by nearly 2 million Californians, a 41 percent decrease in the number of uninsured California citizens and a 22 percent increase in uninsured California citizens obtaining health insurance.[5]

Such important empirical data helps to refute the Eleventh Circuit's assumption, in invalidating the MCR as beyond Congress's authority, that the MCR "forces healthy and voluntarily uninsured individuals" who are "outside the stream of commerce" to purchase insurance. *Florida*, 648 F.3d at 1293, 1300. Such uninsured individuals in fact are not "outside the stream of commerce"; to the contrary, their pervasive lack of health insurance creates free rider and adverse selection problems with a direct and "tangible link to commerce." *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring in the judgment); *see Raich*, 545 U.S. at 25 ("'Where economic activity substantially affects interstate commerce, legislation

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[4] G.F. Kominski, D.H. Roby, K. Jacobs, G. Watson, D. Graham-Squire, C.M. Kinane, D. Gans, and J. Needleman, *Newly Insured Californians Would Fall by More Than 1 Million Under the Affordable Care Act Without the Requirement to Purchase Insurance (*"Kominski & Roby *et al.*"), at 2 & ex.1, UCLA CENTER FOR HEALTH POLICY RESEARCH (2012), http://www.healthpolicy.ucla.edu/pubs/files/calsim_mandate.pdf.

[5] *Id.*

regulating that activity will be sustained.'" (quoting *Morrison*, 529 U.S. at 610)). Whether considered "activity" or "inactivity," "[t]he aggregate effect of that behavior … is just as injurious to interstate commerce." *Seven-Sky v. Holder*, 661 F.3d 1, 19 (D.C. Cir. 2011) (Silberman, J.).

A. The Commerce Clause Permits Congress To Act To Prevent Market Failures Substantially Burdening Interstate Commerce

This Court has long embraced a pragmatic and flexible approach to the Commerce Clause. *See Lopez*, 514 U.S. at 573 (Kennedy, J., concurring) (noting the "Court's definitive commitment to the practical conception of the commerce power"), *quoted in Raich*, 545 U.S. at 25 n.35. As recounted in *Lopez*, 514 U.S. at 553-59, this common-sense understanding of Congress's Commerce Clause authority is the result of the "imprecision of content-based boundaries used without more to define the limits of the Commerce Clause," *id.* at 574 (Kennedy, J., concurring). Regardless of the label attached, this Court's "practical conception" of the Commerce Clause allows Congress to regulate economic behavior whenever there is "a tangible link to commerce," "based on empirical demonstration." *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring in the judgment); *accord Raich*, 545 U.S. at 22.

This Court has recognized that market failures in the interstate economy present a paradigmatic example of a "substantial effect" on interstate commerce. For example, in *United States v. Darby*, 312 U.S. 100, 115 (1941), the Court upheld Congress's

exercise of Commerce Clause authority to cure a market failure involving "the distribution of goods provided under substandard labor conditions." As this Court later recounted, in *Darby*, "Congress had found that substandard wages and excessive hours, when imposed on employees of a company shipping goods into other States, gave the exporting company an advantage over companies in the importing States." *Maryland v. Wirtz*, 392 U.S. 183, 189 (1968). Congress's purpose in enacting a national wage floor "was not only to prevent the interstate transportation of the proscribed product, but to stop the *initial step* toward transportation, production with the purpose of so transporting it." *Darby*, 312 U.S. at 117 (emphasis added). The Court thus acknowledged Congress's power to address *prophylactically* the harms to interstate commerce caused by the violation of fair labor standards that, if left unregulated, would create a race to the bottom among the several States. *See id.* at 117-18; *see also Westfall v. United States*, 274 U.S. 256, 259 (1927) ("[W]hen it is necessary in order to prevent an evil to make the law embrace more than the precise thing to be prevented [Congress] may do so.").

Likewise, in *Wickard v. Filburn*, 317 U.S. 111 (1942), this Court upheld Congress's restriction on the amount of wheat individual farmers were permitted to grow, even if, like the farmer in *Wickard*, the wheat was solely for home consumption and thus "outside" the stream of commerce. *See id.* at 114-15. *Wickard* found it permissible for Congress to "lay[] a restraining hand on the self interest of the regulated," even if this would result in "*forcing* some farmers into the market to buy what they could provide for themselves." *Id.* at 129 (emphasis added). As recognized by the D.C. Circuit, "the logic of

[*Wickard*] would apply to force any farmer, no matter how small, into buying wheat in the open market." *Seven-Sky*, 661 F.3d at 17 (Silberman, J.). Such government action was nonetheless upheld because failure in the wheat market was a "substantial effect" on commerce that Congress was authorized to address. *Wickard*, 317 U.S. at 129.

B. Pervasive Lack Of Health Insurance, Together With Mandatory Provision Of Health Care, Causes Market Failures Substantially Burdening Interstate Commerce

As the Commerce Clause authorized Congress to ameliorate the market failures in *Darby* and *Wickard*, so too does it empower Congress to regulate the market failures caused by a pervasive lack of health insurance. Here, the Commerce Clause enables Congress to require individuals to spend funds in order to prevent the free-rider and adverse-selection problems that currently result in spiraling costs of uncompensated care and health insurance premiums for the insured. The mere fact that a law would "compel Americans *outside the insurance market*" to purchase health insurance, *Florida*, 648 F.3d at 1300, is not an impediment to Congress acting when "the aggregate effect" of individuals failing to purchase insurance "is just as injurious to interstate commerce," *Seven-Sky*, 661 F.3d at 119.

Equally unproblematic is the fact that Congress is regulating conduct at a time prior to when "uninsured individuals actually enter the stream of commerce and consume health care," *Florida*, 648 U.S. at 1295. As *Darby* and *Wickard* illustrate, this Court has long understood the Commerce Clause to

empower Congress to act prophylactically to stop the "initial step" of a market failure, *Darby*, 312 U.S. at 118. The MCR is thus consistent with this Court's Commerce Clause jurisprudence, which empowers Congress to regulate market failures that "substantially affect interstate commerce." *Raich*, 545 U.S. at 17.

The pervasive health care market failures that Congress addressed with the MCR are in significant part the result of prior legislative action, including efforts by both state and federal governments to require the provision of health care even to those who cannot afford health insurance, cannot obtain it, or choose to go without it. As one court of appeals opinion accurately described the problem, to forego health insurance "is to save nothing and to rely on something else—good fortune or the good graces of others—when the need arises." *Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 557 (6th Cir. 2011) (Sutton, J., concurring in part). When neither good fortune nor good grace is available, however, federal and state laws still "require hospitals to accept many of these patients without regard to their capacity to pay." *Id.* at 562.

Specifically, more than half a century ago, Congress enacted the Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946), which requires hospitals receiving federal funds for construction or renovation to provide care to "all persons residing in the territorial area" and to provide a "reasonable volume" of free care to indigent patients. *See* 42 U.S.C. § 291c(e). In subsequent years, this "reasonable volume" ballooned into virtually unlimited access to free care when Congress in 1986 enacted the Emergency Medical Treatment and Active Labor

Act ("EMTALA") as part of COBRA, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 (1986).

Under EMTALA, all hospitals that receive Medicare funds are required to screen and stabilize, if possible, "any patient" with an "emergency medical condition." 42 U.S.C. § 1395dd(a), (b). Many States, including California, have replicated EMTALA by imposing on hospitals similar requirements for treating uninsured patients.[6]

What constitutes an "emergency" under these federal and state statutes has been ill-defined; indeed, many uninsured persons have used hospitals as "doctors of first resort," seeking care for routine illnesses that insured persons would have treated by a private family doctor or specialist.[7] Hospitals, charged with both an external duty of care and often an internal policy not to turn away needy patients,[8]

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[6] *See, e.g.*, Cal. Welf. & Inst. Code § 17000 ("Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.").

[7] *See* California Hospital Ass'n, *Report on California Hospitals, the Economy, and Health Care Reform*, at 3 (Aug. 2009), http://www.calhospital.org/sites/main/files/file-attachments/CHA SpecialRprtHCR-809.pdf ("Individuals without a routine source of health care often use hospital emergency departments as the entry point to primary and other health care services."); *cf.* 42 U.S.C. § 18091(a)(2)(A) (finding that some individuals "make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers").

[8] *See* Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health*

have been loath to challenge a condition as a "non-emergency" since EMTALA and state laws generally restrict transfers of unstabilized patients and authorize civil fines and private causes of action for statutory violations. *See, e.g.*, *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 250-51 (1999) (per curiam) (discussing 42 U.S.C. § 1395dd(c), (d)); Cal. Health & Safety Code § 1371.4; Fla. Stat. § 395.1041; La. Rev. Stat. § 40:2113.4.

Though EMTALA may reflect a laudable desire to provide "adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured," *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1255 (9th Cir. 1995) (quoting H.R. Rep. No. 241, 99th Cong., 1st Sess. (1986), *reprinted in* 1986 U.S.C.C.A.N. 726-27), in the 25 years since EMTALA's passage uncompensated care and its attendant costs have burgeoned. To begin with, the sheer growth in the number of uninsured persons has expanded the scope of the market failure. Nationally, the number of uninsured persons has ballooned from between 21 and 31 million in 1998 to nearly 50 million today.[9] These figures include both those individuals who have chosen to "self-insure," an illusory concept, *see Seven-Sky*, 661 F.3d at 19, as

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Care System, at 2, NEW AMERICA FOUNDATION HEALTH POLICY PROGRAM ISSUE BRIEF #3 (Dec. 2006), http://www.newamerica.net/files/nafmigration/HealthIBNo3.pdf ("Many hospitals—especially public hospitals and some non-profit hospitals—have long traditions of providing all the care their patients need, regardless of ability to pay.").

[9] *See* Trisi *et al.*, *supra* n.3; Congressional Budget Office, HOW MANY PEOPLE LACK HEALTH INSURANCE AND FOR HOW LONG, at 2 (May 2003), http://www.cbo.gov/ftpdocs/42xx/doc4210/05-12-Uninsured.pdf.

well as those individuals denied coverage as a result of pre-existing conditions and other factors.[10] These individuals consume spiraling amounts of "uncompensated care," which Congress found to total $43 billion in 2008, 42 U.S.C. § 18091(a)(2)(F), and are transferred throughout the entire economy through higher insurance premiums, which are on average over $1,000 a year, *id.*

States like California have experienced a similar growth. TCE-sponsored research found that over 5.9 million California citizens lacked health insurance for all or part of 2009.[11] In the wake of the recent recession, the number of uninsured persons in California has swelled from 18.9 percent of the State's population in 2008 to 21.9 percent of its population in 2011,[12] making California the sixth highest in the

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[10] As the Eleventh Circuit recognized, Congress found that "many of the uninsured desire insurance but have been denied coverage or cannot afford it" as they were hindered by private insurers "try[ing] to protect themselves against unhealthy entrants through medical underwriting, especially in the individual market." *Florida*, 648 F.3d at 1245 (citing 42 U.S.C. § 18091(a)(2)(J)). Those individuals who were denied insurance, were charged higher premiums, or were offered only limited insurance due to preexisting conditions range from 9 million to 12.6 million. *Id.*

[11] *See* Shana Alex Lavarreda & Livier Cabezas, *Two Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform*, at 2 ex. 1, UCLA HEALTH POLICY RESEARCH BRIEF (Feb. 2011), http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=478.

[12] Elizabeth Mendez, *State of the States: Texas and Mass. Still at Health Coverage Extremes in U.S.*, GALLUP, Sept. 6, 2011, http://www.gallup.com/poll/149321/texas-mass-health-coverage-extremes.aspx; Elizabeth Mendez, *State of the States: Texans Most Likely to Be Uninsured, Mass. Residents Least*, GALLUP,

Nation in terms of percentage of uninsured residents.[13] These massive numbers of individuals who lack health insurance have concomitantly produced large quantities of uncompensated care: In California alone, uncompensated care totaled $9.6 billion in 2006.[14]

Nor are these individuals "outside" the health care system. Rather, these uninsured persons regularly utilize the free "emergency" care guaranteed by EMTALA: In 2009, more than 80 percent of individuals with no insurance for part of the year, and over 55.5 percent of individuals with no insurance at all, sought medical services and/or prescription drugs.[15] These visits—many unanticipated and exigent—include hospital emergency departments, as well as in-patient and out-patient hospital care,[16] which "are the most expensive and often the least efficient point of entry into the system when primary and preventive care would have helped the patient if they had been available."[17]

C. The MCR Demonstrably Helps To Correct These Health Care Market Failures

The MCR falls well within Congress's authority under the Commerce Clause because, as the em-

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Mar. 11, 2011, http://www.gallup.com/poll/146579/Texans-Likely-Uninsured-Mass-Residents-Least.aspx.

[13] Mendez, *supra* n.12.

[14] Harbage & Nichols, *supra*, n.8, at 2.

[15] UCLA Analysis of Medical Expenditure Panel Survey Data (2009), meps.ahrq.gov/mepsweb.

[16] *Id.*

[17] Cal. Hosp. Ass'n, *supra* n.8, at 3.

pirical data demonstrates, it will help to correct the identified failures in the health care market. Most uninsured or underinsured individuals lack adequate safeguards to cover their medical costs, resulting in more than one out of every three dollars spent on care for the uninsured to be uncompensated. Nationally, uninsured individuals pay for only approximately 37 percent of their care; third-party sources, such as government programs and charities, pick up another 26 percent; and the remaining 37 percent, nearly $43 billion in 2008, consists of uncompensated care.[18]

Congress found that health care providers and insurance companies spread these costs to insured individuals through elevated rate structures for medical procedures and/or higher insurance premiums. *See* 42 U.S.C. § 18091(a)(2)(F). Since "[p]roviders do not have unlimited pockets to secretly finance the health care provided to millions of uninsured (and underinsured) patients,"[19] they recover these missing billions "primarily by increasing charges for those with private insurance."[20] Nationwide, "this translated into a surcharge of $368 for

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[18] Families USA, *Hidden Health Tax: Americans Pay a Premium*, at 2 (May 2009), http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf.

[19] Harbage & Nichols, *supra* n.8, at 2.

[20] Families USA, *supra* n.18, at 6; *see also* Harbage & Nichols, *supra* n.8, at 2 ("Hospitals and physicians anticipate the fact that the uninsured will seek care each year. They prepare for this reality by: [s]etting prices for the insured that are higher than expected costs."). Health care providers cannot turn to state and federal government programs to cover the cost, since those programs use regulations and contracts to set provider payments in advance. Families USA, *supra* n.18, at 6.

individual premiums and a surcharge of $1,017 for family premiums in 2008 due to uncompensated care."[21] In California, in 2006, this "cost-shift" resulted in an additional $455 in average annual premiums for individuals and an additional $1,186 for families.[22] By 2009, those costs had risen to $500 and $1,400, respectively.[23]

The ACA and the MCR address these "aggregate effect[s]" that are "injurious to interstate commerce," *Seven-Sky*, 661 F.3d at 19, at their "initial step," *Darby*, 312 U.S. at 117. Using a California-specific database, TCE-sponsored research demonstrates that, with the MCR, the ACA will allow an additional 1.91 million non-elderly California citizens to have health insurance coverage in 2019, a 41 percent reduction in the number of uninsured California citizens.[24] Yet without the MCR, the ACA would add 1 million fewer California citizens, reducing the number of uninsured California citizens by less than 20 percent.[25] And those who would be insured under the ACA without the MCR would be more expensive to cover, as the individuals who purchase health insurance without the MCR tend to be sicker.[26] The MCR thus "significantly reduc[es] the number

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[21] *Id.* at 7.

[22] Harbage & Nichols, *supra* n.8, at 2.

[23] Ben Furnas & Peter Harbage, *The Cost Shift from the Uninsured*, at 2 (Center for American Progress), Mar. 24, 2009, http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf.

[24] Kominski & Roby *et al.*, *supra* n.4, at 2 & ex.1.

[25] *Id.*

[26] *Id.* at 2.

of the uninsured," both nationally and in California. 42 U.S.C. § 18091(a)(2)(F).

And, as Congress predicted, because the MCR, "together with the other provisions of the [ACA], significantly reduces the number of uninsured, it also "lower[s] health insurance premiums" for all as the costs of uncompensated care drop. *Id.* One analysis, for example, estimates that the MCR will reduce premiums by over 20 percent for individuals and over 10 percent for families.[27]

Thus, the MCR addresses the fundamental market failures created in part by laudable governmental efforts to care for those who cannot afford to care for themselves. This empirical demonstration brings the MCR well within Congress's authority under the Commerce Clause.

II. THE MINIMUM COVERAGE REQUIREMENT IS WITHIN CONGRESS'S AUTHORITY UNDER THE NECESSARY AND PROPER CLAUSE AS AN ESSENTIAL PART OF THE ACA

Recent California-specific data further supports Congress's authority to enact the MCR under the Necessary and Proper Clause, in conjunction with its authority under the Commerce Clause. Congress is authorized to "regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce." *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the

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[27] *See* Jonathan Gruber, *Health Care Reform Is A "Three-Legged Stool"*, at 4 (Center for American Progress), Aug. 2010, http://www.americanprogress.org/issues/2010/08/pdf/repealing_reform.pdf.

judgment) (citing *Lopez*, 514 U.S. at 561); *accord Comstock*, 130 S. Ct. at 1956 ("[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 the authority's 'beneficial exercise.'" (quoting *McCulloch*, 17 U.S. at 413, 418)).

The MCR is necessary to implement Congress's authority to remedy the failures in the interstate health care market because it is the key means of resolving the free-rider and cost-shifting problems associated with those individuals who refrain from purchasing health insurance. As Petitioners explain (Pet'rs Br. 32) and the data confirms, the MCR provides an "extra incentive" for individuals to obtain health insurance: without the MCR, the number of newly insured California citizens would be 54 percent lower in 2019.[28]

The MCR, moreover, is an "essential part[] of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the [activity at issue] were regulated." *Raich*, 545 U.S. at 24-25 (quoting *Lopez*, 514 U.S. at 561). Without the MCR, the "adverse selection" problem, in which "individuals … wait to purchase health insurance until they need[] care," 42 U.S.C. § 18091(a)(2)(I), would rapidly increase insurance premiums for all Americans. By requiring those individuals who are cheaper to insure to purchase insurance, the MCR protects against uncompensated care while expanding the overall risk pool and lowering administrative costs, *id.* making it feasible for insurance companies

[28] *See* Kominski & Roby *et al.*, *supra* n.4, at 2-3 & ex.1.

to discontinue their practice of reducing costs by excluding those with pre-existing conditions, *see id*. § 18091(a)(2)(J).

By contrast, enforcing a prohibition on discrimination against pre-existing conditions *without* requiring that individuals obtain health insurance would permit individuals to wait until they become sick to purchase insurance. As Congress discovered from observing States that experimented with just such a regulatory regime, allowing individuals to obtain insurance "on their way to the hospital" creates a "death spiral" of skyrocketing insurance premiums and plummeting insurance coverage.[29]

California-specific empirical data robustly supports Congress's prediction that the MCR "will minimize this adverse selection and broaden the health insurance risk pool." 42 U.S.C § 18091(a)(2)(I). In the absence of the MCR, by 2019 over 1 million California citizens will forego health insurance coverage, leaving 3.76 million California citizens without health insurance.[30] Furthermore, the California

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[29] *See* Amitabh Chandra, Jonathan Gruber, and Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts,* at 1, 364 New Eng. J. Med. 293 (2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1013067 (noting that "the five U.S. states with such regulations (known as 'community rating') are among the states with the highest nongroup insurance premiums"); Amicus Brief of the Governor of Washington Christine Gregoire in Support of Defendants/ Appellants 11-12, *Florida v. U.S. Dep't of Health & Human Services*, 648 F.3d 1235 (11th Cir. 2011) (No. 11-11021) (describing how "Washington actually experienced the 'death spiral' that can occur in the private insurance market when coverage for preexisting conditions is required without universal coverage").

[30] Kominski & Roby *et al.*, *supra* n.4, at 2 & ex.1. Massachusetts' experience with a requirement to purchase insurance

citizens who do purchase health insurance will be more likely to have chronic illnesses and pay more for their insurance coverage.[31] If these dynamic effects occur, further raising premiums and driving healthy individuals from the insurance pool, the feedback will only further hamper the ACA, limiting its expansion of insurance in California to only 13 percent.[32] The MCR's absence thus "will critically undercut gains from reform."[33]

The MCR is therefore not just conducive but "essential to a comprehensive regulation of interstate commerce." *Raich*, 545 U.S. at 37 (Scalia, J., concurring the judgment). And because the MCR is a "measure[] necessary to make the interstate regulation [of commerce] effective," Congress was authorized to pass it "in conjunction with [its] regulation of an interstate market." *Id.* at 38.

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provides additional empirical support, as there, once the requirement came into effect, there was "an enormous increase in the number of healthy enrollees" in Massachusetts' health insurance program for low-income Massachusetts residents. Chandra *et al.*, *supra* n.29, at 3.

[31] Kominski & Roby *et al.*, *supra* n.4, at 3.

[32] *Id.*

[33] Gruber, *supra* n.27, at 3.

CONCLUSION

For the foregoing reasons, and for those stated by the Petitioners, the Court should reverse the decision below and uphold the constitutionality of the MCR.

Respectfully submitted,

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