No. 11-398

In The

Supreme Court Of The United States

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,

v.

STATE OF FLORIDA, ET AL.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF OF AMICUS CURIAE ADVOCACY FOR PATIENTS WITH CHRONIC ILLNESS, INC. IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Beginning in 2014, the minimum coverage provision of the Patient Protection and Affordable Care Act, Pub.L. No. 111-148, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, will require non-exempted individuals to maintain a minimum level of health insurance or pay a tax penalty. 26 U.S.C. § 5000A. The question presented is whether Congress had the power under Article I of the Constitution to enact the minimum coverage provision.

Other questions before the Court are not addressed in this brief.

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STATEMENT OF INTEREST

Amicus Advocacy for Patients with Chronic Illness, Inc. is a tax exempt organization that provides free information, advice and advocacy services to patients with chronic illnesses nationwide, in areas including health insurance. By definition, all of our clients have pre-existing conditions. The minimum coverage provision is necessary in order to extend affordable insurance to people with pre-existing conditions who, currently, often are unable to obtain individual insurance of any kind for any amount of money. Because we believe that the conversion of the insurance market to a universal guaranteed issue model is perhaps the most important legal advance to benefit people with largely invisible chronic illnesses, we strongly support the minimum coverage provision, and, thus, the Petitioners' position in this case.

SUMMARY OF THE ARGUMENT

The Patient Protection and Affordable Care Act (the Act) will end insurers' heretofore legal discrimination against people with pre-existing conditions by prohibiting them from refusing coverage due to a pre-existing health condition. 42 U.S.C.A. § 300gg-1(a). This is necessary to ensure that health insurance is available to all Americans – clearly a valid exercise of Congress's Commerce powers. U.S. Const. Art. I, Sec. 8, Clause 3.

The unavailability of insurance coverage of people with pre-existing conditions is a tremendous problem in America – the young man living in a motel in rural Idaho after losing his business, his house, even his car, just to pay for health care that might allow him to survive; the entrepreneur afraid to start her own business because she cannot get health insurance for any amount of money; the father with hepatitis C who is wasting away, desperately trying to remain employed to provide for his young child. Congress has the authority under the Commerce Clause to address this injustice by requiring insurers to cover people with pre-existing conditions.

However, in order to achieve this legitimate goal, Congress also had to create the minimum coverage provision, 26 U.S.C.A § 5000A, to ensure that healthy people would be part of the insurance "pool" so as to control the costs of health insurance; and to provide for affordability through community-rating and advance payment tax credits. 42 U.S.C.A. § 300gg; 26 U.S.C.A. § 36B. Because Congress had authority under the Commerce Clause to require coverage of people with pre-existing conditions, these additional provisions, including the minimum coverage provision, were valid Congressional actions under the Necessary and Proper Clause. U.S. Const. Art. I, Sec. 8, Clause 18.

Requiring insurance coverage of people with pre-existing conditions arguably does more to advance the cause of people with largely invisible chronic illnesses than any other law, including the Americans with Disabilities Act. 42 U.S.C § 12010,

et seq. Some of us who are disabled will regain our health and our ability to contribute to society by working and earning our way. Others of us will be rid of unimaginable suffering and fear. Nothing Congress is empowered to do would provide more critical legal protection to people with pre-existing conditions, including chronic illnesses.

Universal guaranteed issue, community-rated insurance is the promise of equal access to health insurance and, thus, health care for the chronically ill. Taking away this promise, to be fulfilled on January 1, 2014, cannot and should not be justified by a construction of the Commerce Clause that does not fully appreciate that the underlying goal of the statutory scheme was to cover the uninsured and, in particular, those with pre-existing conditions. This is life and death for us; it is nowhere near as important for those who complain about having to purchase insurance that will, without doubt, become valuable to them at some point in their lives. The relative weight of these competing interests clearly favors a finding that the minimum coverage provision is constitutional.

We strongly urge the Court to consider the effect of its decision on the millions of Americans with pre-existing conditions whose lives will be touched, one way or another, by the judgment in this case.

ARGUMENT

I. CONGRESS ACTED WITHIN ITS "COMMERCE CLAUSE" POWERS TO ADDRESS THE LACK OF ADEQUATE COVERAGE FOR PERSONS WITH PREEXISTING CONDITIONS

The Patient Protection and Affordable Care Act (the Act), has, at its core, a three-legged stool comprised of the guaranteed issue provision, 42 U.S.C.A. § 300gg-1(a), 300gg-3(a); the minimum coverage provision, 26 U.S.C.A § 5000A; and affordability provisions including the community rating provision, 42 U.S.C.A. § 300gg, and advanced payment tax credits. 26 U.S.C.A. § 36B. This statutory scheme is intended to make insurance available and affordable for the millions of Americans who are uninsured.

The guaranteed issue provision directly addresses the needs of persons with preexisting conditions, in particular. Approximately 57.2 million, 22.4 percent, of all Americans under the age of 65 have a pre-existing condition that could lead to a denial of coverage. Families USA Foundation, *Health Reform: Help for Americans with Pre-Existing Conditions* at 2 (May 2010) (visited November 22, 2011) <http://www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions.pdf.> (hereinafter "Families USA"). Every income group and every racial and ethnic group are included in these numbers. *Id.* at 4, 5.

Private insurers regularly and ever more increasingly deny coverage to persons with preexisting conditions, as one Congressional study found:

> *From 2007 through 2009, the four largest for-profit health insurance companies, Aetna, Humana, UnitedHealth Group, and WellPoint, refused to issue health insurance coverage to more than 651,000 people based on their prior medical history.* On average, the four companies denied coverage to one out of every seven applicants based on a pre-existing condition.
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> *From 2007 through 2009, the number of people denied coverage for pre-existing conditions increased at a rapid rate.* The number of individuals denied coverage by Aetna, Humana, UnitedHealth Group, and WellPoint increased from 172,400 in 2007 to 257,100 in 2009, an increase of 49%. During the same period, applications for enrollment increased by only 16%.

H. A. Waxman and B. Stupak, *Memorandum: Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market,* U.S. House of Representatives, Committee on Energy and Commerce (October 12, 2010) (emphases in original)

(visited Nov. 23, 2011) <http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Pre-Existing.Condition.Denials.Individual.Market.2010.10.12.pdf>.

Currently, people with pre-existing conditions cannot obtain insurance unless they meet hyper-technical rules that render them "HIPAA eligible," which means that they are entitled to purchase one of two guaranteed issue options offered in their state.[1] If they fail to meet those requirements, they are shut out of the individual health insurance market entirely; and even under group plans, they must wait as long as twelve months to obtain coverage of their pre-existing conditions. 29 U.S.C.A. § 1181(a)(twelve month waiting period for group plans); 36 Okl. Stat. Ann. § 6534.B.3 (twelve month waiting period for individual high risk pool coverage of pre-existing conditions); Tex. Ins. Code Ann. § 1506.155 (twelve month waiting period for individual high risk pool coverage or pre-existing conditions); N.C. Gen. Stat. § 58-50-210 (twelve

[1] To be HIPAA eligible, an individual must have had at least eighteen months of creditable coverage, the last day of which must be in a group health insurance plan; they must have exhausted their COBRA (if any); and they must not have had a break in coverage of sixty-three days or more. 42 U.S.C.A. § 300gg-41(b); 29 U.S.C.A. § 1181(c)(2)(A). Each state is required to designate two guaranteed issue options, unless the state has established a "high risk pool," which then becomes the guaranteed issue option for HIPAA eligibles. 42 U.S.C.A. § 300gg-41(c). A HIPAA eligible individual may purchase one of these two guaranteed issue options or join the state's high risk pool without the waiting period that applies to non-HIPAA eligibles. *See* Georgetown University Health Policy Institute Consumer Guides for each state's option(s) for HIPAA eligibles. (visited Dec. 3, 2011) <http://www.healthinsuranceinfo.net/> .

month waiting period for individual high risk pool coverage of pre-existing conditions). This not only has driven millions of people into "medical bankruptcy," D. U. Himmelstein, et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, The American Journal of Medicine (2009) (*visited Nov.28, 2011*) <http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf>, but it also leaves people with pre-existing conditions – by definition, people who need health care – without the care they need to remain productive and even alive.

Uninsured adults are six times more likely than those with private insurance to go without needed healthcare due to its cost, and seven times more likely than insured adults to have gone without preventive care in the last year. Families USA, *supra,* at 10. Uninsured adults with chronic conditions are particularly at risk. Among uninsured adults with chronic conditions, nearly one-third went without needed medical care; approximately 59 percent delayed care; and 60 percent did not fill a prescription due to cost. *Id.*

Although we counsel patients with chronic illnesses in many areas of law and insurance – from health and disability insurance coverage appeals to employment, school, and housing issues – more than fifteen and one-half percent of Advocacy for Patients with Chronic Illness's caseload consists of people with pre-existing conditions who simply cannot find health insurance. Thirty-five percent of the calls we receive about the inability to access health insurance center on affordability. For a patient with Crohn's

disease, gastroparesis, high blood pressure, and asthma, for example,[2] going without medication for a six to twelve month waiting period (if they are not HIPAA eligible) is unthinkable; indeed, it may result in hospitalization or even death.

These are not just numbers; they are people. In November 2011 alone, we heard from a woman with hepatitis C and cirrhosis of the liver who was laid off from her job of fourteen years. Her insurance was terminated coincident with the termination of her employment, as is the norm. She had to get her weekly injection of interferon, but she had not yet received her COBRA notice and hence was not HIPAA eligible, and she had no way to cover the cost of this injection; the provider would not treat her without active insurance. We spoke with a woman with a genetic illness that affects her blood's clotting who has been unemployed for two years, and although she exhausted her COBRA benefits, she cannot afford her state's guaranteed issue option, which would cost more than $1000 per month, and is no longer HIPAA eligible. She was rejected by Medicaid for having $30 too much in her bank account. A young man called because the local county hospital told him that he probably has Crohn's disease, but he could not receive a definitive

[2]It is quite common for people with chronic illnesses to have more than one illness. J. Jaff, et al., "Living With Chronic Illness: A Prescription for Advocacy," (Advocacy for Patients with Chronic Illness 2011)<http:// www.advocacy for patients .org/pdf/Living-with-Chronic-Illness-paper.pdf> (in a survey of 1513 patients with chronic illnesses, sixty-two percent reported that they have more than one chronic illness; forty percent had between two and four chronic illnesses; and twenty-two percent had more than five chronic illnesses).

diagnosis – and, thus, treatment – without a colonoscopy, which he cannot afford. We heard from a woman with reflex sympathetic dystrophy (also known as complex regional pain syndrome) who was diagnosed after her insurance went into effect, but the insurer took the position that she had to wait a full year before any services for her pre-existing condition would be covered. Another woman wrote for her friend whose husband lost his job and, thus, his insurance; her friend has lupus and cannot afford any health care, without which she will die.

This is a small sample of what we hear, day in and day out, from all over the United States. People with pre-existing conditions who do not have insurance are desperate. Although we direct them to prescription drug patient assistance programs, which provide free or discounted medications; federally qualified health centers, which provide free or discounted primary health care; and not-for-profit hospitals, where they may receive "charity care," there is no way to get blood drawn or have a CT scan or undergo surgery when you do not have insurance.

Congress addressed the lack of coverage for persons with pre-existing conditions, including chronic illnesses, primarily through the guaranteed issue provision, scheduled to take effect January 1, 2014. 42 U.S.C.A. § 300gg-1(a), 300gg-3(a). This provision would require insurers to extend insurance coverage to people with pre-existing conditions.[3]

[3] For the period prior to January 1, 2014, the Act creates a federal guaranteed issue option, but there is a six month waiting period for coverage under this Pre-existing Condition Insurance Plan. 42 U.S.C.A. § 18001(d)(2).

This requirement that insurance companies cover people with pre-existing conditions constitutes a regulation of the business of insurance. Although states historically have been the primary regulators of the business of insurance, Congress indisputably has the power under the Commerce Clause to regulate the insurance industry. U.S. Const. Art. I, Sec. 8, Clause 3. *See generally Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 217-20 (1979) (discussing *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944) and passage of the McCarran-Ferguson Act). Indeed, Congress repeatedly has regulated the health insurance industry, such as through the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.), and the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Pub. L. 99-272, 100 Stat. 227 (codified as amended at 29 U.S.C. §§ 1161-68), and has regulated the industry again in the Act by various provisions not challenged by any party as exceeding the scope of the Commerce Clause. *See, e.g.,* 42 U.S.C.A. § 18031 (requiring states to create health insurance exchanges); 42 U.S.C.A. § 18022 (requiring the Secretary of the Department of Health and Human Services to define an essential benefits package that all insurance sold on an exchange must include).

Thus, Congress acted within its Commerce Clause powers to meet the glaring need for health insurance coverage for people with pre-existing conditions, including people with chronic illnesses.

II. CONGRESS ACTED WITHIN ITS POWERS UNDER THE "NECESSARY AND PROPER" CLAUSE IN ADOPTING THE MINIMUM COVERAGE REQUIREMENT

Requiring coverage of people with pre-existing conditions would not in itself achieve the goal of covering the uninsured because adding only people with pre-existing conditions to the health care "pool" would drive up the cost of insurance to unaffordable levels, and drive healthy people out of the pool when they realize they are subsidizing the ill. For example, beginning in 1973, New York required insurers to cover people with pre-existing conditions and, as a result, premiums increased and healthy people dropped out of the plans, leaving only people with "high health care needs," which led to "skyrocket[ing]" premiums. A. Hartocollis, "New York Offers Costly Lessons on Insurance," *New York Times* (April 17, 2010) (visited November 28, 2011) <http://www.nytimes.com/2010/04/18/nyregion/18insure.html?scp=2&sq=preexisting+conditions&st=nyt>. In order to spread the cost of covering people with pre-existing conditions, healthy people also must be included in the "pool" without the option of opting out, and, thus, minimum coverage must be required of all Americans.[4] Otherwise, not only would people with pre-existing conditions drive up the cost of insurance, but "many individuals [would]

[4]There are, of course, other excellent reasons to require everybody to purchase insurance, memorialized in Congressional findings and explained in detail in Petitioners' brief. *See, e.g.,* 42 U.S.C.A. § 18091(a)(2)(I).

wait to purchase health insurance until they needed care." 42 U.S.C.A. § 18091(a)(2)(I).

Thus, Congress built the second leg of the stool: the minimum coverage requirement. It found that the requirement is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C.A. § 18091(a)(2)(I).

Finally, Congress had to construct the third leg. If Congress is to require Americans to buy insurance that many find unaffordable, there must be mechanisms to ensure that they can afford the insurance they are required to buy. Thus, Congress created the affordability provisions: the community rating provision, 42 U.S.C.A. § 300gg; and advanced payment tax credits that work as a subsidy to assist low-income individuals and families to purchase insurance. 26 U.S.C.A. § 36B.

Without the minimum coverage provision, the stool could not stand. And stand it must if people with largely invisible chronic illnesses are to be able to purchase and afford health insurance.

Because the minimum coverage provision is necessary to the requirement that insurers offer coverage of pre-existing conditions, its adoption was within Congress's power under the Necessary and Proper Clause. U.S. Const. Art. 1, Sec. 8, Clause 18. That clause "grants Congress the legislative authority to enact a . . . statute . . . that is rationally

related to the implementation of a constitutionally enumerated power." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (citing *Sabri v. United States,* 541 U.S. 600, 605 (2004)). The Necessary and Proper Clause extends to statutes adopted to regulate commerce under the Commerce Clause. *See Gonzales v. Raich,* 545 U.S. 1, 22 (2005) (holding that because "Congress had a rational basis" for concluding that a statute implements Commerce Clause power, the statute falls within the scope of congressional "authority to 'make all Laws which shall be necessary and proper' to 'regulate Commerce . . . among the several States' " (ellipsis in original)).

Indeed, even if the test were not "rational[ ] relat[ionship]," but a balancing test, the adoption of the minimum coverage provision would be appropriate under the Necessary and Proper Clause. For people with largely invisible chronic illnesses, the guaranteed issue provision is the most important legal protection to be enacted – ever. It is more important than the Americans with Disabilities Act, which, for the most part, does not protect people who are too sick to work on a regular basis.[5] Indeed,

[5] The ADA provides protection only if one is able to perform the "essential functions" of one's job, and the courts have held that attendance is an "essential function," so people with chronic illnesses often are fired for disability-based absenteeism. *Robertson v. Amtrak/Nat'l R.R. Passenger Corp*., 400 F. Supp. 2d 612, 627 (S.D.N.Y. 2005) (holding an employee who is excessively absent is not performing the essential functions of his job); *Barnett V. Revere Smelting & Refining Corp*., 67 F.Supp.2d 378, 392 (S.D.N.Y. 1999) (except in the unusual case in which an employee effectively can perform all work-related duties at home, an employee who doesn't come to work cannot perform any of his job functions, essential or otherwise); *Mescall v. Marra*, 49 F.Supp.2d 365, 374 (S.D.N.Y. 1999)

universal guaranteed issue insurance will allow people afflicted by chronic illness to stay employed, get off disability – live. For the first time, people with chronic illnesses will have equal access to insurance, which, in turn, will provide them with the ability to obtain the care they need.

Obviously, the minimum coverage provision places a burden on people to pay for insurance, even with the affordability provisions. But that burden consists only of the obligation to purchase insurance that will, without doubt, become valuable to the purchasers at some point in their lives. That burden is far less weighty than the life or death issue that coverage for pre-existing conditions is for us with chronic illnesses. No Respondent in this case has a stronger countervailing interest.[6]

(absenteeism is permissible motive for adverse employment decision); *Tyndall v. Nat'l Educ. Centers, Inc. of California*, 31 F.3d 209, 213 (4th Cir. 1994) ("in addition to possessing the skills necessary to perform the job in question, an employee must be willing and able to demonstrate those skills by coming to work on a regular basis.").

[6] We also agree with Petitioners that Congress also had the power to adopt the minimum coverage provision under the Commerce Clause, but believe that the power to adopt the provision under the Necessary and Proper Clause is at least equally certain.

CONCLUSION

For all of these reasons, the decision of the United States Court of Appeals for the Eleventh Circuit should be reversed.

Respectfully submitted,

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