

No. 11-398

In The
Supreme Court of The United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET
AL., PETITIONERS

v.

STATE OF FLORIDA, ET AL.

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

**BRIEF FOR *AMICI CURIAE* AMERICAN
NURSES ASSOCIATION; AMERICAN
ACADEMY OF PEDIATRICS; AMERICAN
MEDICAL STUDENT ASSOCIATION;
DOCTORS FOR AMERICA; NATIONAL
HISPANIC MEDICAL ASSOCIATION; AND
THE NATIONAL PHYSICIANS ALLIANCE IN
SUPPORT OF PETITIONERS AND REVERSAL
ON THE MINIMUM COVERAGE PROVISION**

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TABLE OF CONTENTS

INTERESTS OF AMICI CURIAE.....	7
SUMMARY OF THE ARGUMENT.....	8
ARGUMENT.....	10
I. FINANCING HEALTH COSTS IS AN ECONOMIC ACTIVITY THAT SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE	10
A. Uninsured Americans Frequently Delay Care Until Their Conditions Become Much More Difficult And Expensive To Treat.	11
B. The Costs of Caring For Uninsured Americans Drive Up The Cost of Medicare and Private Insurance Plans	16
II. ADVERSE SELECTION – THE ACTIVITY OF DELAYING THE PURCHASE OF HEALTH INSURANCE UNTIL AFTER A PERSON REQUIRES CARE – IS AN ECONOMIC ACTIVITY THAT MAY BE REGULATED BY CONGRESS	17
III. THERE ARE CLEAR DOCTRINAL LIMITS ON CONGRESSIONAL POWER WHICH ENABLE THIS COURT TO UPHOLD THE	

MINIMUM COVERAGE PROVISION WITHOUT RAISING THE SPECTER OF A FEDERAL POLICE POWER	22
A. A Decision Upholding The Minimum Coverage Provision Would Preserve Existing Limits On Congressional Power And Need Not Authorize Hypothetical Laws Requiring Consumers To Purchase Other Products	22
B. Public Health Laws Regulating Individuals Who Are Not Presently Engaged In Commerce Are an Important Element Of Long- Existing Federal Law.....	25
CONCLUSION	29

Table of Authorities

Cases

<i>Florida v. Dep't of Health and Human Servs.</i> , 648 F.3d 1235 (11th Cir. 2011).....	21, 24
<i>Florida v. Dep't of Health and Human Servs.</i> , 780 F. Supp. 2d 1256 (N.D. Fla. 2010).....	23
<i>Gibbons v. Ogden</i> , 22 U.S. (9 Wheat.) (1824)	8, 25
<i>Thomas More Law Center v. Obama</i> , 651 F.3d, 529 (6th Cir. 2011).....	8, 10, 22
<i>United States v. Comstock</i> , 130 S. Ct. 1949, 1968 (2010).....	20
<i>United States v. Lopez</i> , 514 U.S. 549 (1995)	8, 20, 25
<i>United States v. Morrison</i> , 529 U.S. 598 (2000).....	22
<i>United States v. Wrightwood Dairy Co.</i> , 315 U.S. 110 (1942)	20

Statutes

Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd.....	15
Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010).....	passim
Public Health Service Act of 1944, 42 U.S.C. § 264.26	

Other Authorities

Adele M. Kirk, <i>Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts</i> , 25 J. of Health Politics, Pol'y and L. 133 (2000).....	19, 24
Alan C. Monheit et al., <i>Community Rating and Sustainable Individual Health Insurance Markets in New Jersey</i> , 23 Health Affairs 167 (2004)	19
Andrew P. Wilper et al., <i>Health Insurance and Mortality in US Adults</i> , 99 Am. J. Pub. Health 2289 (2009)	9

Ben Furnas & Peter Harbage, Ctr. for Am. Progress, <i>The Cost-shift from the Uninsured 2</i> (March 24, 2009)	16, 23
Congressional Budget Office, <i>Effects of Eliminating the Individual Mandate to Obtain Health Insurance 2</i> (June 16, 2010)	18
David I. Auerbach & Arthur L. Kellermann, <i>A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family</i> , 30:9 <i>Health Affairs</i> 1 (2001).....	10
Institute of Medicine, <i>America’s Uninsured Crisis: Consequences for Health and Health Care</i> (February 2009).....	11, 12, 14
Institute of Medicine, <i>Care Without Coverage: Too Little, Too Late</i> (2002).	13, 15
Institute of Medicine, <i>Health Insurance is a Family Matter</i> (2002)	11
Institute of Medicine, <i>Health Insurance is a Family Matter</i> (2002).	15
Jay J. Shen and Elmer L. Washington, <i>Disparities in Outcomes Among Patients With Stroke Associated With Insurance Status</i> , 38 <i>Stroke</i> 1010 (2007).....	14
Jonathan Gruber, Ctr. for Am. Progress, <i>Health Care Reform is a ‘Three-Legged Stool</i> 1 (Aug. 5, 2010) .	18
Kaiser Family Foundation, <i>The Uninsured: A Primer</i> (Oct. 2011)	9
Kevin T. Stroupe et al., <i>Chronic Illness and Health Insurance Related-Job Lock</i> , 20 <i>J. Pol’y Analysis & Mgmt.</i> 525 (2001)	9
Maine Bureau of Insurance, <i>White Paper: Maine’s Individual Health Insurance Market</i> (January 22, 2001)	19, 24
Oral Argument Tr. of <i>United States v. Comstock</i> , 130 S. Ct. 1949 (2010).....	26

Peter G. Szilagyi, et al., <i>Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York</i> , 117 <i>Pediatrics</i> 486 (2006)	13
President's Council of Advisors on Science and Technology, <i>Report to the President on U.S. Preparations for 2009—H1N1 Influenza</i> (Aug. 7, 2009)	27
Thomas R. McLean, <i>International Law, Telemedicine & Health Insurance: China as a Case Study</i> , 32 <i>Am. J. L. and Med.</i> 7, 21 (2006).....	17
Vickie Yates Brown, et al., <i>Health Care Reform in Kentucky - Setting the Stage for the Twenty-First Century?</i> , 27 <i>N. Ky. L. Rev.</i> 319 (2000).....	19

INTERESTS OF AMICI CURIAE¹

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 Respondents 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 experience that patients who put off needed care due to lack of insurance often end up

¹ Pursuant to Supreme Court Rule 37.6, 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. All parties have consented to the filing of *amicus* briefs and have filed letters reflecting their blanket consent with the Clerk.

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 and informed perspective on the impact of the Affordable Care Act and the capacity to offer an expert perspective 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.

SUMMARY OF THE ARGUMENT

The Patient Protection and Affordable Care Act's, Pub L. No. 111-148, 124 Stat. 119 (2010) ("ACA") minimum coverage provision² regulates trade in health care services by requiring most Americans to finance their health costs through insurance. It regulates an activity known as "adverse selection" where consumers delay purchasing health insurance until after they become likely to receive more in benefits than they pay into an insurance plan. And it is an essential element of a broader scheme regulating the national health care and health insurance markets.

Each of these three facts is sufficient to render the minimum coverage provision constitutional. As

² The ACA labels its requirement that nearly all Americans either carry insurance or pay a tax penalty, § 1501(a)(2)(G), the "Requirement to Maintain Minimum Essential Coverage." § 1501. The provision is referred to as the "minimum coverage provision" throughout this brief.

Chief Justice Marshall explained, “no sort of trade can be carried on” that Congress’ power over interstate commerce “does not extend” to except for wholly local matters that concern only one state. *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 193–195 (1824). This power includes the power to regulate trade in health services, a power which is “plenary” and which “acknowledges no limitations, other than are prescribed in the constitution.” *Id.* at 196–97.

Additionally, “[n]o one is inactive when deciding how to pay for health care,” *Thomas More Law Center v. Obama*, 651 F.3d, 529, 561 (6th Cir. 2011) (Sutton, J., concurring), and this Court’s precedents extend the commerce power to all economic activity that substantially affects interstate commerce. *Gonzales v. Raich*, 545 U.S. 1, 17 (2005). Delaying the purchase of insurance in order to effectively transfer the cost of health care to third parties is an activity that substantially affects interstate commerce, and thus may be regulated by Congress.

Finally, even if the minimum coverage provision could not be enacted on its own, this Court should affirm it as an “essential part of a larger regulation of economic activity.” *Id.* at 24 (quoting *United States v. Lopez*, 514 U.S. 549, 561 (1995)). As this brief explains, much of the ACA’s broader regulation of the health insurance industry simply cannot function effectively absent a minimum coverage provision.

ARGUMENT

I. FINANCING HEALTH COSTS IS AN ECONOMIC ACTIVITY THAT SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE

Approximately 50 million non-elderly Americans do not have health insurance, Kaiser Family Foundation, *The Uninsured: A Primer* 1 (Oct. 2011), leaving millions unable to pay for adequate medical care. This is not simply a public health crisis – according to one study uninsured accounted for more than 44,000 deaths in 2005, Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 Am. J. Pub. Health 2289, 2295 (2009) – it also is one of the greatest burdens on the American economy. Sixty-two percent of all personal bankruptcies are caused in part by medical expenses. ACA § 10106(a). Thousands of workers forgo a new job opportunity or the chance to start of business because they cannot afford to leave a job that provides them with health insurance. Kevin T. Stroupe et al., *Chronic Illness and Health Insurance Related-Job Lock*, 20 J. Pol’y Analysis & Mgmt. 525, 525 (2001).

Between 1999 and 2009, “the percentage of GDP devoted to health care climbed from 13.8 percent to 17.6 percent, and per capita health spending grew from \$4,600 to just over \$8,000.” David I. Auerbach & Arthur L. Kellermann, *A Decade Of Health Care Cost Growth Has Wiped Out*

Real Income Gains For An Average US Family, 30:9 Health Affairs 1 (2001). This cost the median family that receives health insurance through an employer nearly 90 percent of their income gains during this ten year period after accounting for taxes and non-health care inflation. *Id.* at 3.

For the uninsured, who are a primary beneficiary of the Affordable Care Act, the picture is even worse. Although virtually everyone participates in the national market for health care regardless of whether or not they finance the cost of this care through insurance, *Thomas More Law Center*, 651 F.3d at 544, consumers who do finance their care through insurance are more likely to receive swift and inexpensive treatment, while the uninsured are prone to delay care until their condition worsens into something much more severe and costly to treat. Additionally, the uninsured are far more likely to shift the costs of their health care to people with insurance or to federal and state governments. Thus, the economic activity of financing health care purchases through insurance or some other method substantially affects interstate commerce by impacting both the cost of care and who winds up paying for it.

A. Uninsured Americans Frequently Delay Care Until Their Conditions Become Much More Difficult And Expensive To Treat.

Many health conditions and illnesses, if caught early and treated with appropriate follow-up care, can be relatively inexpensive to resolve. Many

more 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).

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 is associated with deterioration of their medical conditions. 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." *Uninsurance Among Adults* 469. 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.

Severe conditions, which have reached that point because of delayed care, are often drastically more expensive to treat than if they had been treated in a timely fashion. Moreover, patients who suffer from severe medical conditions are frequently less able to be productive in the workplace, and may even develop a chronic condition that permanently decreases their ability to earn a living. Had these patients been insured, however, a great deal of these substantial effects on interstate commerce would have been avoided.

B. The Costs of Caring For Uninsured Americans Drive Up The Cost of Medicare and Private Insurance Plans

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.

Additionally, 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., uninsured patients frequently receive uncompensated care from these emergency rooms. These costs are then transferred to patients with insurance. *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 patients with insurance. Congress found that "[t]his cost-shifting increases family

premiums by on average over \$1,000 a year.” ACA § 10106(a). Similarly, one study estimated that cost shifting due to uncompensated care 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”).

“Faced with \$43 billion in uncompensated care, Congress reasonably could require *all* covered individuals to pay for health care now so that money would be available later to pay for *all* care as the need arises.” *Thomas More*, 651 F.3d at 557 (Sutton, J., concurring). This is especially true because this uncompensated care affects nearly every consumer in the health insurance market by driving up the cost of their premiums. Because this cost-shifting is an activity that substantially affects interstate commerce, laws regulating it—such as the minimum coverage provision—fit comfortably within Congress’ authority.

II. ADVERSE SELECTION – THE ACTIVITY OF DELAYING THE PURCHASE OF HEALTH INSURANCE UNTIL AFTER A PERSON REQUIRES CARE – IS AN ECONOMIC ACTIVITY THAT MAY BE REGULATED BY CONGRESS

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). This activity, whereby insurance consumers time the purchase of insurance to coincide with when they most need it, substantially affects interstate commerce by requiring insurers to develop complex countermeasures that drive millions Americans out of the health insurance market.

Insurers typically defend against adverse selection by screening potential customers with disabilities or preexisting conditions, but the ACA specifically forbids this practice. § 2704. When insurers are unable to deploy their normal countermeasures against adverse selection, the result 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.”) This “death spiral” is also a substantial effect on interstate commerce caused by people engaging in adverse selection.

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 the minimum coverage provision enables an insurance market to continue functioning when insurers cannot screen out high risk consumers, it is necessary to ensure that the ACA's insurance reforms function effectively.

The Congressional Budget Office estimates that premiums will increase drastically absent a minimum coverage provision due to the problem of adverse selection:

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. Many states that 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 insurance reforms similar to those in the ACA 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 ACA's insurance reforms from creating a fatal adverse selection spiral. Thus, even if adverse selection were not itself an economic activity that substantially affects interstate commerce – and it is – the minimum coverage provision still must be upheld as an “essential part of a larger regulation of economic activity.” *Raich*, 545 U.S. at 24 (quoting *Lopez*, 514 U.S. at 561). *see also United States v. Comstock*, 130 S. Ct. 1949, 1968 (2010) (Kennedy, J., concurring in the judgment) (explaining that Congress may exercise its necessary and proper power to ensure that another provision of law does “not put in motion a particular force . . . that endangers others”). Congress’s Necessary and Proper power is at its apex when, as is the case here, there is an empirically-demonstrated link between a provision of law regulating interstate commerce and another provision chosen to ensure that the commercial regulation functions effectively. *See id.* at 1966 (Kennedy, J., concurring in the judgment) (“When the injury is whether a federal law has sufficient links to an enumerated power to be within the scope of federal authority, the analysis depends not on the number of links in the congressional-power chain but on the strength of the chain.”); *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the

judgment) (“where Congress has the authority to enact a regulation of interstate commerce, ‘it possesses every power needed to make that regulation effective.’” (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19, 62 S Ct. 523, 526 (1942))).

III. THERE ARE CLEAR DOCTRINAL LIMITS ON CONGRESSIONAL POWER WHICH ENABLE THIS COURT TO UPHOLD THE MINIMUM COVERAGE PROVISION WITHOUT RAISING THE SPECTER OF A FEDERAL POLICE POWER

A. A Decision Upholding The Minimum Coverage Provision Would Preserve Existing Limits On Congressional Power And Need Not Authorize Hypothetical Laws Requiring Consumers To Purchase Other Products

Respondents “cannot find real support . . . in either the text of the Constitution or Supreme Court precedent.” *Seven-Sky v. Holder*, No. 11-5074, 2011 U.S. App. Lexis 22566, at *47 (Nov. 8, 2011). Nevertheless, the Eleventh Circuit accepted their invitation to strike down the minimum coverage provision because it believed that any decision upholding this law would “lack[] cognizable limits.” *Florida v. Dep’t of Health and Human Servs.*, 648 F.3d 1235, 1313 (11th Cir. 2011).

This decision is incorrect. Nothing in the two court of appeals decisions upholding the minimum coverage provision disturbs existing doctrinal limits on laws focused merely on non-economic concerns or on those focused on wholly intrastate matters. See *Seven-Sky*, 2011 U.S. App. Lexis 22566, at *49 (“[T]he distinctions that separate national and local spheres have been understood as those between intrastate and interstate commerce, and between traditional, non-economic areas of state concern and those involving commerce.” (citing *United States v. Morrison*, 529 U.S. 598, 617–619 (2000)); *Thomas More Law Center*, 651 F.3d. at 558 (Sutton, J., concurring) (“As *Lopez* and *Morrison* suggest, a majority of the Court still appears to accept the line between regulating economic and non-economic conduct, which is why a general murder or assault statute would exceed congressional power. Measured by these conventional commerce clause benchmarks, the minimum-essential-coverage provision passes.”)) A short list of wholly non-economic laws that are unconstitutional under either of the lower court decisions upholding the minimum coverage provision includes nationwide bans on murder, rape or assault, federal laws regulating sexual morality, and many federal laws governing the family.

Additionally, as explained above, the minimum coverage provision regulates the economic activity of adverse selection. Adverse selection is a problem peculiar to the insurance market. Thus, a decision upholding the minimum coverage provision as a valid regulation of the economic activity of adverse selection would not raise the specter of a

federal policy power because the problem of adverse selection simply does not exist in ordinary consumer markets such as the market for broccoli or automobiles.

Moreover, *Raich's* doctrine preserving laws that comprise an “essential part of a larger regulation of economic activity” also provides a meaningful doctrinal limit on Congressional power. Despite the district court’s suggestion that a decision upholding the minimum coverage provision would also require this Court to uphold laws mandating the purchase of broccoli or automobiles, *See Florida v. Dep’t of Health and Human Servs.*, 780 F. Supp. 2d 1256, 1289 (N.D. Fla. 2010), there is no federal law which depends upon mandatory car ownership or mandatory food 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, broccoli or automobile purchase mandates do not comprise an “essential part” of any broader regulatory scheme.

Nor, for that matter, could they. As explained above, the minimum coverage provision is essential to the ACA’s insurance regulations because the health insurance market simply does not function like other markets. 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). Similarly, the national market for vegetables is not in danger of collapsing if Congress does not require people to buy broccoli. Nor is there a risk that Americans will cease to be able to obtain automobiles absent a law requiring the purchase of GM cars. 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).

B. Public Health Laws Regulating Individuals Who Are Not Presently Engaged In Commerce Are an Important Element Of Long-Existing Federal Law

The Eleventh Circuit rejected Respondents' extra-constitutional claim that an individual is immune to regulation under the Commerce Clause if they are not presently "engaged in commerce, or activities associated with commerce" because it determined that "the formalistic dichotomy of activity and inactivity" does not provide "a workable or persuasive enough answer in this case." *Florida*, 648 F.3d at 1285–86. Nevertheless, the Eleventh Circuit's decision striking down the minimum coverage provision relied, at least in part, on its

belief that the minimum coverage provision is an "unprecedented exercise of congressional power" because past decisions of this Court "all involved attempts by Congress to regulate preexisting, freely chosen classes of activities."³ *Id.* at 1286 & 1311.

Public health laws, however are centrally focused on the subject of preventing or mitigating illness or injury—and illness or injury are almost never the result of a "freely chosen" class of activity. This is especially true with respect to airborne illnesses, which can be transmitted even to entirely dormant individuals whose only activity is breathing.

³ To the extent that the Eleventh Circuit deemed the minimum coverage provision unconstitutional because it disapproved of the mechanism Congress chose to regulate interstate commerce—requiring individuals to carry insurance—that decision was in error. Under this Court’s precedents, Congress’ Commerce power extends to all laws which regulate “activities that substantially affect interstate commerce.” *United States v. Lopez*, 514 U.S. 549, 559 (1995). Once this Court determines that the activity subject to regulation under the minimum coverage provision—trade in health services and adverse selection within the health insurance market—substantially affects interstate commerce, that is the end of the Court’s enumerated powers inquiry. *Id.*; *See also Rancho Viejo, LLC v. Norton*, 334 F.3d 1158, 1160 (D.C. Cir. 2003) (Roberts, J., dissenting from the denial of rehearing en banc) (emphasizing that the Commerce Clause inquiry hinges upon whether “the activity being regulated” substantially affects interstate commerce (emphasis in original)). All mechanisms which are not “prescribed” by another provision of the Constitution fall within Congress’ “plenary” authority to regulate activity that substantially affects interstate commerce. *Gibbons*, 22 U.S. (9 Wheat.) at 196–97; *see McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 421 (1819) (“Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.”)

Moreover, public health laws regulating individuals who are not presently engaged in a "freely chosen" class of activity are far from unprecedented. Federal law has long regulated individuals who develop serious and highly contagious illnesses, regardless of whether the individual subject to that regulation is presently engaged in interstate commerce or any other form of activity. The Public Health Service Act of 1944 permits the Surgeon General to "provide for the apprehension and examination of any individual reasonably believed to be infected with a communicable disease in a qualifying stage and . . . to be a probable source of infection to individuals who, while infected with such disease in a qualifying stage, will be moving from a State to another State." 42 U.S.C. § 264. Regulations promulgated under this Act authorize "the detention, isolation, quarantine, or conditional release of individuals, for the purpose of preventing the introduction, transmission, and spread of the communicable diseases" listed in an executive order. 42 C.F.R. § 70.6. Individuals subject to such detention, isolation or quarantine are not required to be presently engaged in any kind of activity in order to fall within the Surgeon General's authority.

There is more than a century of precedent establishing that quarantine laws fit within Congress' commerce authority. In *Morgan's S.S. Co. v. Louisiana Bd. of Health*, 118 U.S. 455 (1886), this Court explained that Congress possesses the power to displace state quarantine laws because such laws

“whether passed with intent to regulate commerce or not, must be admitted to have that effect.” *Id.* at 465. More recently, Justice Scalia expressed this view more succinctly: “if anything relates to interstate commerce, it's communicable diseases.” Oral Argument Tr. of *United States v. Comstock*, 130 S. Ct. 1949 (2010) at 30.

Thus, federal health laws regulating presently inactive individuals under the Commerce Clause are far from “unprecedented,” as the Eleventh Circuit suggested. Rather, longstanding federal law subjects individuals with communicable diseases to massive intrusions upon their liberty—up to and including detention for the length of their illness—even if those individuals engaged in no activity whatsoever.

Moreover, were this Court to embrace the Eleventh Circuit’s novel rule prohibiting Congress from regulating anything other than “preexisting, freely chosen classes of activities,” it could have disastrous effects. To give just one example, approximately three or four times every century new subtypes of influenza arise which sweep through a human population that has no significant immunity to them. President’s Council of Advisors on Science and Technology, *Report to the President on U.S. Preparations for 2009—H1N1 Influenza* 7 (Aug. 7, 2009) *available at* http://www.whitehouse.gov/assets/documents/PCAST_H1N1_Report.pdf. Although these pandemics vary in severity, their effects can be calamitous. In 1918 and 1919, a global influenza pandemic killed an estimated 40–100 million people worldwide, between

500,000 and 750,000 of whom were in the United States. *Id.* at 8.

Managing a pandemic that is similarly widespread, virulent and deadly could not be done by fifty divergent state governments. It would require the kind of coordinated response that can only be conducted by the federal government. Yet, if this Court were to adopt the rule suggested by the Eleventh Circuit, federal officials would lack the authority to regulate people who became infected through no “freely chosen” action of their own.

CONCLUSION

For the forgoing reasons, *amici* respectfully submit that this Court should reverse the decision of the Eleventh Circuit with respect to the minimum coverage question.