CONSTITUTIONALITY OF THE INDIVIDUAL MANDATE

Brief by Kamala D. Harris (additional counsel listed in brief) before Henry E. Hudson

March 7, 2011

11-1057 & 11-1058
IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

COMMONWEALTH OF VIRGINIA,
ex rel. Kenneth T. Cuccinelli, II,
in his Official Capacity as Attorney General of Virginia,
Plaintiff-Appellee/Cross-Appellant,

v.

KATHLEEN SEBELIUS,
Secretary of the Department of
Health and Human Services,
in her Official Capacity,
Defendant-Appellant/Cross-Appellee.

On Appeal from the United States District Court
for the Eastern District of Virginia
No. 3:10-cv-188
The Honorable Henry E. Hudson, Judge

AMICUS CURIAE BRIEF OF THE STATES OF CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, IOWA, MARYLAND, NEW YORK, OREGON, AND VERMONT IN SUPPORT OF APPELLANT

KAMALA D. HARRIS
Attorney General of California
MANUEL M. MEDEIROS
State Solicitor General
TRAVIS LEBLANC
Special Assistant Attorney General
DANIEL J. POWELL
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, California 94102
Telephone: (415) 703-5830
Email: daniel.powell@doj.ca.gov
Attorneys for Amici Curiae
State of California

DOUGLAS F. GANSLER
Attorney General of Maryland
WILLIAM F. BROCKMAN
Deputy Solicitor General
JOSHUA N. AUERBACH
Assistant Attorney General
200 St. Paul Place, 20th Floor
Baltimore, Maryland 21202
Telephone: (415) 703-5830
Email: jauerbach@oag.state.md.us
Attorneys for Amici Curiae
State of Maryland

(Other counsel listed on next page)

Additional Counsel:

GEORGE C. JESPEN
Attorney General of Connecticut
55 Elm Street
Hartford, Connecticut
(860) 808-5270
Attorneys for Amicus Curiae
State of Connecticut

ERIC T. SCHNEIDERMAN
Attorney General of New York
120 Broadway, 25th Floor
New York, New York 10271
(212) 416-8020
Attorneys for Amicus Curiae
State of New York

JOSEPH R. BIDEN, III
Attorney General Of Delaware
820 N. French Street
Wilmington, DE 19801
(302) 577-8400
Attorneys for Amicus Curiae
State of Delaware

JOHN R. KROGER
Attorney General of Oregon
1162 Court Street NE
Salem, Oregon 97301
(503) 378-6002
Attorneys for Amicus Curiae
State of Oregon

DAVID M. LOUIE
Attorney General of Hawaii
425 Queen Street
Honolulu, Hawaii 96813
(808) 586-1500
Attorneys for Amicus Curiae
State of Hawaii

WILLIAM H. SORRELL
Attorney General of Vermont
109 State Street
Montpelier, Vermont 05609
(802) 828-3173
Attorneys for Amicus Curiae State of Vermont

TOM MILLER
Attorney General of Iowa
1303 East Walnut Street
Des Moines, Iowa 50319
(802) 828-3181
Attorneys for Amicus Curiae State of Iowa

[*Editors' note*: Table of Contents and Table of Authorities omitted.]

[*1] INTEREST OF THE AMICI STATES

Amici,[1] the States of California, Connecticut, Delaware, Hawaii, Iowa, Maryland, New York, Oregon, and Vermont[2] have a vested interest in protecting the health, safety, and welfare of their citizens, interests that are advanced through the Patient Protection and Affordable Care Act of 2010[3] ("ACA"). Moreover, as sovereign States, Amici have a vital interest in ensuring that constitutional principles of federalism are respected by the federal government, as they are here.

As part of their responsibility to help provide access to affordable care for their citizens, Amici have engaged in varied, creative, and determined state-by-state efforts to expand and improve health insurance coverage in their States and to contain healthcare costs. Despite some successes, these state-by-state efforts have fallen short. As a consequence, Amici have concluded that a national solution, embracing principles of cooperative federalism, is necessary. [*2]

California's dire situation illustrates the problems facing Amici. In 2009, more than 7.2 million Californians—nearly one in four people under the age of 65—lacked insurance for all or part of the year. More than 5.5 million Californians who could not afford private insurance were enrolled in government-sponsored health plans, which will cost the State a projected $42 billion in the next fiscal year. Of those funds, $27.1 billion comes from the General Fund, which faces a $25 billion deficit.

Oregon and Maryland too are grappling with the spiraling cost of medical care and health insurance. Despite a variety of legislative efforts to increase access to insurance coverage, 21.8% of Oregonians and 16.1% of Marylanders lack health insurance. The Urban Institute has predicted that without comprehensive healthcare re-

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[1] Amici file this brief pursuant to Federal Rule of Appellate Procedure 29(a).

[2] Although Massachusetts has filed a brief detailing its unique experience with its health care reform, it agrees with the arguments set forth in this brief.

[3] The ACA refers to the Patient Protection and Affordable Care Act, Public Law 111–148 and the Healthcare and Education Reconciliation Act of 2010, Public Law 111–152.

form, 27.4% of Oregonians and 20.2% of Marylanders will lack health insurance by 2019. In 2009, Oregon spent $2.6 billion on Medicaid and the Children's Health Insurance Program. Without comprehensive healthcare reform, the cost is expected to double to $5.5 billion by 2019.

The ACA provides important tools for the States, in partnership with the federal government, to provide their citizens needed access to affordable and reliable healthcare. The law strikes an appropriate—and constitutional—balance between national requirements that will expand [*3] access to affordable healthcare while providing States with flexibility to design programs that achieve that goal for their citizens. Amici urge this Court to reverse the decision of the district court and uphold this necessary law.

STATUTORY BACKGROUND

The ACA represents a reasonable means of grappling with the United States' healthcare crisis. The minimum coverage provision, which requires non-exempt adults to maintain adequate health coverage, is but one part of a comprehensive healthcare reform law intended to increase Americans' access to affordable healthcare. The ACA relies in large part on an expansion of the current market for health insurance, building upon existing state and federal partnerships to improve access to and the quality of healthcare in the United States.

Although the minimum coverage provision requires individuals to purchase health insurance, most people will continue to receive coverage through their employer or through expanded access to Medicaid. The ACA expands the number of employers who offer insurance to their workers by requiring businesses with more than fifty employees to begin providing health insurance in 2014. ACA § 1513. Small businesses have already started taking advantage of the significant tax breaks intended to encourage [*4] such expansion, including some of the 333,000 businesses eligible in the Fourth Circuit. ACA § 1421.[4] The ACA also expands access to Medicaid to

[4] http://www.irs.gov/pub/newsroom/count per_state_for_special_post_card_notice.

individuals who earn less than 133 percent of the federal poverty level, and funds 100 percent of the cost until 2017. ACA § 2001(a). California was one of the first States to obtain a waiver from the federal government that allows it to offer this expanded coverage to Californians prior to 2014.[5]

Finally, for those individuals who do not obtain health insurance from their employer or from government-run plans, the ACA makes affordable coverage more readily available. It eliminates annual and lifetime caps on health insurance benefits so that individuals maintain coverage during a catastrophic illness. 42 U.S.C. § 300gg-11. The ACA authorizes States to create health insurance exchanges that will allow individuals, families, and small businesses to leverage their collective bargaining power to obtain more competitive prices and benefits. 42 U.S.C. § 18031. Maryland, for instance, has already received two grants totaling $7.2 million to support its [*5] implementation of this provision.[6] The ACA provides tax incentives for low-income individuals to purchase their own insurance through insurance exchanges. ACA § 1401. Starting in 2014, the ACA prohibits insurance companies from refusing to cover individuals with preexisting conditions. 42 U.S.C. § 300gg-3. A significant number of individuals who are uninsured are unable to purchase insurance or are required to pay higher premiums due to a preexisting condition, which can include common illnesses such as heart disease, cancer, asthma, or even pregnancy.[7] The ACA will thus dramatically increase the availability of insurance for previously uninsurable individuals.

One component of these comprehensive reforms is the minimum coverage provision, which requires that an applicable individual maintain "minimum essential coverage" each month. ACA § 1501. Minimum essential coverage includes Medicare or Medicaid, an employer-sponsored plan, or a plan offered through a health in-

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pdf (last accessed Feb. 27, 2011).

[5] California Department of Healthcare Services, *California Bridge to Reform: A Section 1105 Waiver* (Nov. 2010).

[6] http://www.healthcare.gov/center/states/md.html (last accessed Feb. 27, 2011).

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

surance exchange. *Id*. As discussed below, the minimum coverage provision is important for two [*6] reasons. First, it ensures that individuals take responsibility for their own care rather than shifting those costs to society. Second, the elimination of caps on benefits and the requirement that insurance companies insure individuals with preexisting conditions are unsustainable if participants in the healthcare market are allowed to postpone purchasing insurance until an acute need arises.

SUMMARY OF ARGUMENT

Under the Commerce Clause, Congress has the authority to enact the minimum coverage provision, as it substantially affects interstate commerce and is essential to the proper application of the ACA. The Supreme Court has recognized three broad categories of activities Congress may regulate consistent with its authority "to regulate commerce," including (1) "the use of the channels of interstate commerce," (2) "the instrumentalities of interstate commerce," and (3) "activities having a substantial relation to interstate commerce." *United States v. Lopez*, 514 U.S. 549, 558–59 (1995). Although the Supreme Court has in the past addressed the scope of "activities" that Congress may regulate, it has never suggested that a distinction between activity and inactivity exists or that it is a relevant inquiry for purposes of the Commerce Clause. [*7]

Rather, the minimum coverage provision is included in Congress's power to regulate activities that substantially affect interstate commerce. Exercising this power, Congress may regulate economic activities that, in the aggregate, have a substantial effect on interstate commerce. *See Gonzalez v. Raich*, 545 U.S. 1, 17 (2005). In addition, Congress may regulate noneconomic activity so long as the regulation is "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Lopez*, 514 U.S. at 561. The minimum coverage provision is a justifiable exercise of Congress's Commerce Clause authority because (1) the aggregate effect of maintaining a minimum level of insurance coverage has a substantial effect on commerce, and (2) the comprehensive solution to health

insurance reform would be undercut without the minimum coverage provision.

Moreover, the minimum coverage provision is also justified by the Necessary and Proper Clause. Not only is the minimum coverage provision necessary, it is a proper exercise of federal authority that does not alter the essential attributes of state sovereignty. Indeed, identical arguments were made and rejected when Congress first began regulating conditions of labor and when it passed the Social Security Act. [*8]

ARGUMENT

I. CONGRESS POSSESSES THE AUTHORITY UNDER THE COMMERCE CLAUSE TO ENACT THE MINIMUM COVERAGE PROVISION

A. As a Threshold Matter, the Distinction between Activity and Inactivity is Illusory and Has No Basis in Commerce Clause Precedent.

Regardless of whether the minimum coverage provision is seen to regulate activity or "inactivity," it is within Congress's power to regulate interstate commerce. In arguing that the minimum coverage provision is outside the bounds of the Commerce Clause, Virginia does not question the substantial effects that the failure to purchase insurance has on interstate commerce, but rather argues that the decision not to purchase health insurance is "inactivity" that could not be regulated by Congress. (Dist. Ct. Paper No. 89 at 16.) The supposed distinction between "activity" and "inactivity," however, is illusory, and has no basis in Supreme Court jurisprudence.

Many regulated activities could conceivably be characterized as "inactivity," illustrating the false distinction between the two. For instance, the failure to comply with draft registration requirements, 50 U.S.C. App. 451 *et seq.,* can be viewed as inaction or as an affirmative act of disobedience. The failure to appear for federal jury duty as required by 28 U.S.C. § 1854(b) can likewise be characterized as "inactivity" rather than as [*9] an affirmative action to evade jury service. As Justice Scalia has observed, "[e]ven as a legislative matter…the intelligent line does not fall between action and inac-

tion." *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296 (1990) (Scalia, J., concurring). Judge Kessler of the United States District Court for the District of Columbia reached a similar conclusion in granting the government's motion to dismiss a related suit:

> It is pure semantics to argue that an individual who makes a choice to forego health insurance is not "acting," especially given the serious economic and health-related consequences to every individual of that choice. Making a choice is an affirmative action, whether one decides to do something or not do something. To pretend otherwise is to ignore reality.

Mead v. Holder, 2011 WL 61139, *18 (D.D.C. Feb. 22, 2011). The distinction between activity and inactivity carries no analytical weight and does not furnish a proper basis for determining the scope of congressional power.

The distinction between activity and inactivity also has no basis in Commerce Clause jurisprudence. Virginia notes that Supreme Court cases construing the limits of the Commerce Clause power refer to economic *activity*, and concludes from this observation that Congress can regulate only activity, not inactivity. (Dist. Ct. Paper No. 89 at 5, 13, 16.) That argument improperly elevates descriptive statements into a holding. The Court's [*10] discussions of "economic activity" in those cases were not focused on whether the law at issue regulated activity rather than inactivity, but on whether the activity was economic or noneconomic in nature.[8] *See, e.g., United States v. Morrison*, 529 U.S. 598, 610 (2000) ("Both petitioners and Justice Souter's dissent downplay the role that the economic nature of the regulated activity plays in our Commerce Clause analysis. But a fair reading of *Lopez* shows that the noneconomic, criminal nature

[8] Similarly, some argued that Congress could not regulate local manufacture prior to transit because Supreme Court decisions discussing the Commerce Clause had, prior to that point, addressed only the regulation of goods in transit. The Court ultimately rejected the distinction between the two. As Robert Stern observed, "'the Court talked about movement because that was all that was needed to talk about to decide the cases before it,' and not because it meant to limit the scope of federal power." Mark A. Hall, *Commerce Clause Challenges to Healthcare Reform*, 159 U. Penn. L. Rev. at ___ (forthcoming June 2011), available at: http://ssrn.com/abstract=1747189 (quoting Robert L. Stern, *That Commerce Which Concerns More States than One*, 47 Harv. L. Rev. 1335, 1361 (1934)).

of the conduct at issue was central to our decision in that case."). Thus, the proper question is not whether the decision refusing to purchase health insurance is "action" or "inaction," but rather whether, in the aggregate, such decisions substantially affect interstate commerce. There can be no doubt that they do. [*11]

B. Decisions Whether to Purchase Health Insurance Have a Substantial Effect on Interstate Commerce That Congress May Directly Regulate.

The decision whether to maintain health insurance coverage has a "substantial relation to interstate commerce," *Lopez*, 514 U.S. at 558, and is a permissible exercise of Congress's Commerce Clause authority. In deciding to regulate activities that have a substantial effect on interstate commerce, Congress may consider the aggregate effects of those activities. "When Congress decides that the 'total incidence' of a practice poses a threat to a national market, it may regulate the entire class." *Raich*, 545 U.S. at 17. This Court need not determine whether the decision to purchase health insurance substantially affects interstate commerce when considered in the aggregate, but "only whether a 'rational basis' exists for so concluding." *Id.* at 22 (quoting *Lopez*, 514 U.S. at 557). Here, Congress had a rational basis for concluding that individuals' decisions not to purchase health insurance, but rather to pay (or attempt to pay) for their medical care only at the time such care is delivered has a substantial effect on interstate commerce.

As Secretary Sebelius demonstrates in her brief (p. 31-33), the minimum coverage provision has a substantial effect on interstate commerce. Everyone requires healthcare at some point. Individuals who [*12] lack health insurance, however, shift two-thirds of the cost of their care to state and local officials, amounting to $43 billion nationally in 2008 at a cost of $455 per individual or $1,186 per family each year in California.[9] Maryland has developed a unique regulatory framework that seeks to ensure that such cost-shifting

[9] 42 U.S.C. § 18091(a)(2)(F); Peter Harbage and Len Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Healthcare System* (New America Foundation, Dec. 2006).

occurs as equitably as possible. The State's Health Services Cost Review Commission, a hospital rate-setting body, authorizes the State's hospitals to impose a fee on all patients to reimburse hospitals for the costs associated with providing care to the uninsured. In 2009, when Maryland hospitals provided a total of $999 million in uncompensated care, 6.91% of the charge for any visit to a Maryland hospital reflected a Commission-approved add-on charge to reimburse the hospital for the cost of providing uncompensated care. In other words, a fixed and substantial portion of every Maryland hospital-patient's bill reflects the shifting of costs from supposedly "inactive" individuals to the patient population as a whole.

Requiring individuals to possess health insurance ends this cost-shifting, lowering the costs of healthcare for everyone and reducing the costs to the States of providing such care. The minimum coverage provision will greatly reduce the need to compensate hospitals for uncompensated care, [*13] either directly as Maryland does, or indirectly as is the case in California and most States. The direct impact on interstate commerce described in the Secretary's brief is sufficient to justify Congress's exercise of its Commerce Clause authority.

C. The Minimum Coverage Provision Regulates an Essential Part of a Larger Economic Activity.

The minimum coverage provision is also justified as "an essential part of a larger regulation" of the health insurance industry. *Lopez*, 514 U.S. at 561. It cannot be doubted that Congress has the constitutional authority to regulate the health insurance industry. *See United States v. South-Eastern Underwriters*, 322 U.S. 533 (1944) (Congress possesses Commerce Clause authority to regulate insurance). Indeed, Congress has regulated the health insurance market for decades. *See* Employee Retirement Income Security Act of 1974 (ERISA) (Pub. L. 93-406); Consolidated Omnibus Budget Reconciliation Act (COBRA) (Pub. L. 99-272); Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104-191).

The market for medical services is national in scope, and accounts for 17 percent of the United States's gross domestic product,

or $2.5 trillion.[10] [*14] Congress found that spending for health insurance exceeded $850 billion in 2009. 42 U.S.C. § 18091(a)(2). As Congress recognized, medical supplies, drugs, and equipment used in the provision of healthcare routinely cross state lines. 42 U.S.C. § 18091(a)(2)(B). Many hospital corporations operate in numerous states: the Hospital Corporation of America, for instance, operates 164 hospitals and 106 freestanding surgery centers in 20 states.[11] Moreover, Congress found that the majority of health insurance is sold by national or regional companies. 42 U.S.C. § 18091(a)(2)(B).

As Secretary Sebelius explains in her brief (p. 34–39), the minimum coverage provision is an essential part of the ACA's attempt to provide healthcare access to individuals with preexisting conditions, a group that is among the hardest of the uninsured to cover. The requirement that companies insure individuals with preexisting conditions creates a moral hazard: individuals could simply wait until they are sick to purchase health insurance. Left unmitigated, this "adverse selection" creates an insurance pool that poses an extremely high risk from an insurer's perspective, since individuals who are ill or at high risk of becoming ill will disproportionally purchase health insurance while healthy individuals will remain outside the system. To prevent insurance companies from being forced to raise [*15] premiums to account for this risk, Congress enacted the minimum coverage provision, which prevents freeloaders from refusing to pay for insurance when they know they can buy it when it is needed.

This provision has the additional effect of reducing the need to shift the cost of uncompensated care given to those without insurance onto the States and responsible individuals who have health insurance. *See supra* at 12–13. As a result of the minimum coverage provision, California will no longer be forced to pay the 5-7 percent of public hospitals' operating expenses that resulted from treating uninsured individuals.[12] Nor will Maryland be forced to add a 7 per-

[10] Center for Medicare & Medicaid Services, 2009 National Health Expenditure Data, table 3.
[11] http://www.hcahealthcare.com/about/ (last accessed March 5, 2011).
[12] California HealthCare Foundation, *California's Healthcare Safety Net: Facts and Figures* at 19

cent surcharge to all hospital bills to cover such uncompensated care. The minimum coverage provision will help reduce the almost $43 billion spent nationally on uncompensated care, 42 U.S.C. § 18091(a)(2)(F), and is necessary to the proper functioning of the requirement that insurance companies insure those with preexisting conditions. It is the sort of noneconomic regulation that is essential to a larger regulation of economic activity (the health insurance market generally) that Congress may regulate. *Lopez*, 514 U.S. at 561. [*16]

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

Congress's authority under the Commerce Clause is augmented by the Necessary and Proper Clause, which allows Congress to "make all laws which shall be necessary and proper for carrying into execution" the powers enumerated in the Constitution. U.S. Const., Art. I, § 8. As Justice Scalia has explained, the Necessary and Proper Clause authorizes Congress to "regulate even those intrastate activities that do not substantially affect interstate commerce" as well as "noneconomic local activity" where necessary to make a regulation of interstate commerce effective. *Raich*, 545 U.S. at 35, 37 (Scalia, J., concurring). Thus, even if the requirement that an individual maintain a minimum level of coverage were not considered economic, it is still within Congress's power since it is necessary to lower the cost of health insurance and to effectuate the ban on denying coverage based on preexisting conditions. In rejecting application of the Necessary and Proper Clause, the district court concluded that the minimum coverage provision was not "tethered to a lawful exercise of an enumerated power" and that the provision "is neither within the letter nor the spirit of the Constitution." (Dist. Ct. Paper No. 161 at 24.) This conclusion reflects a [*17] misunderstanding of the purpose and function of the Necessary and Proper Clause.

(Oct. 2010).

1. The Minimum Coverage Provision Furthers Congress's Exercise of Its Commerce Clause Authority.

The minimum coverage provision is in fact tethered to a valid exercise of congressional authority: Congress's power to regulate commerce. It is beyond dispute that the ACA *as a whole*, which regulates the $2.5 trillion national healthcare market, is within Congress's Commerce Clause power. Under the Necessary and Proper Clause, Congress "possesses every power needed to make that regulation effective." *United States v. Wrightwood Dairy Co.,* 315 U.S. 110, 118–19 (1942). Such power is necessarily *in addition to* whatever enumerated power Congress possesses. It is axiomatic that Congress possesses the authority to use all appropriate means adapted to legitimate ends. *McCulloch v. Maryland*, 4 Wheat. 316, 421 (1819). To suggest that Congress must possess some enumerated power to justify the exercise of authority under the Necessary and Proper Clause would render that clause meaningless.

Rather, the appropriate inquiry is whether "the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *United States v. Comstock*, 130 S. Ct. 1949, 1957 [*18] (2010). In making this determination, courts must give Congress "a large discretion as to the means that may be employed in executing a given power." *Lottery Case*, 188 U.S. 321, 355 (1903). The end here is clearly legitimate: to reduce the expense of healthcare, which in 2008 accounted for approximately $2.5 trillion, or 17.6%, of the nation's economy, and to expand access to health insurance as the federal government has been doing since the passage of the Social Security Act in 1965. So too are the means reasonably adapted to this legitimate end. As explained above, *supra* at 14-15, the minimum coverage provision helps eliminate the problem of adverse selection created by expanding the insurance pool and results in reduced insurance premiums and lower costs of healthcare.

2. The Minimum Coverage Provision is a "Proper" Exercise of Congressional Authority

In addition to being necessary, the minimum coverage provision is also proper. Virginia's primary argument as to why the Necessary and Proper Clause does not apply is that the power to enact the minimum coverage provision "would alter the federal structure of the Constitution by creating an unlimited federal power indistinguishable from a national police power." (Dist. Ct. Paper No. 89, at 5–6.) This concern dramatically overstates the authority being claimed by the federal government, and [*19] dramatically understates the extent to which the federal government already regulates a significant portion of the health insurance market.

In *Comstock*, the Supreme Court rejected a Tenth Amendment limitation on the Necessary and Proper Clause much along the lines of what Virginia urges here. The Supreme Court concluded that the "powers 'delegated to the United States by the Constitution' include those specifically enumerated powers listed in Article I along with the implementation authority granted by the Necessary and Proper Clause. Virtually by definition, these powers are not powers that the Constitution 'reserved to the States.'" *Comstock*, 130 S. Ct. at 1962.

Justice Kennedy concurred, expressing his view that "whether essential attributes of state sovereignty are compromised by the assertion of federal power under the Necessary and Proper Clause" should be a consideration in determining whether a power is properly within the federal government's reach. *Id*. at 1967–68. Justice Kennedy identified three examples where the Necessary and Proper Clause should be limited: instances "in which the National Government demands that a State use its own governmental system to implement federal commands"; "in which the National Government relieves the States of their own primary responsibility to enact laws and policies for the safety and well being of their citizens"; or [*20] "in which the exercise of national power intrudes upon functions and duties traditionally committed to the State." *Id*. at 1968. None of these apply here.

a. The Minimum Coverage Provision Does Not Require States to Implement Federal Commands.

First, the Act does not commandeer the States to implement a federal program. To the contrary, the ACA provides States substantial ability to experiment with their own methods of improving their citizens' access to affordable healthcare. Indeed, the ACA is a prime example of cooperative federalism that the Supreme Court has concluded is within Congressional authority. *New York v. United States*, 505 U.S. 144, 167 (1992). For instance, the ACA gives States broad latitude to establish health insurance exchanges in a manner that States determine best meet the needs of their citizens, subject to minimum federal standards. 42 U.S.C. § 18041(b). Even those standards may be waived if a State wishes to provide access to health insurance in a different way. *Id.* § 18052. Or a State may decline to establish an exchange at all. *Id.* § 18041(c).

Similarly, the ACA allows States great latitude in establishing basic health programs for low-income individuals who are not eligible for Medicaid. States may implement new coverage programs for individuals and families with incomes between 133% and 200% of the poverty line. 42 [*21] U.S.C. § 18051. If a State chooses to implement these programs, their citizens would be able to choose a plan under contract with the State instead of one offered in the insurance exchange. *Id.* The State would receive federal funds to operate such a program equal to 95% of the subsidies that would have gone to providing coverage for this group in the exchange. *Id.* § 18051(d)(3). States may also enter into healthcare choice compacts in which two or more States establish such a program. *Id.* § 18053. Or again, a State may choose not to establish such a program and instead allow their citizens to access health insurance exchanges operated by the federal government.

b. States Maintain Primary Responsibility to Protect their Citizens.

Second, the ACA does not relieve States of their primary responsibility to enact laws and policies for the safety and well-being of their citizens. States may choose to enact further reforms to im-

prove over the federal reforms contained in the ACA, much as Massachusetts has done with its landmark healthcare reform law that has served as a model for many of the reforms instituted by the ACA. Indeed, the ACA gives States *additional* authority to regulate insurance companies. Under the authority to review any increases in the premiums set by insurance companies, California passed a law requiring all premium filings to be reviewed and certified by an [*22] independent actuary to ensure that premium costs are accurately calculated. Cal. Stats. 2010, Ch. 661.

c. The ACA Does Not Intrude in an Area Typically Committed to State Control

Third, the ACA does not intrude in an area that has historically been committed solely to the States. While States retain wide latitude to regulate the standards of medical care and the provision of health insurance, the federal government has maintained a presence in the health insurance arena for decades. A prime example is Medicaid, through which the state and federal governments cooperate in order to extend coverage to children, pregnant mothers, and the disabled who are below the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i). Using federal and state funds, States administer Medicaid according to a plan that is approved by the Secretary of Health and Human Services. *Id.* § 1396a(b). States, within federal guidelines, determine which benefits the State will offer, how much doctors are paid, and how the program will operate. Congress's continued involvement in the health insurance market is nothing new.

Aside from Medicaid, Congress has regulated large aspects of the insurance market since the passage of ERISA in 1974. ERISA regulates the provision of employer-sponsored health plans, and limits the ability of insurance companies to deny coverage to individuals with preexisting [*23] conditions. 29 U.S.C. § 1181. ERISA also sets minimum standards for certain aspects of employer-sponsored health insurance, such as requirements for minimum hospital stays following the birth of a child, and parity in mental health and substance abuse benefits. *Id.* §§ 1185(a), 1185a. Congress has twice

revisited its regulation of health insurance since then. Passed in 1986, COBRA requires that employers continue to offer health insurance to individuals and their dependents that otherwise might be terminated, such as if an individual loses his or her job. *Id*. §§ 1161 *et seq*. HIPAA, passed in 1996, set federal requirements for maintaining the privacy of medical information, 42 U.S.C. §§ 1320d-1 *et seq*. and further limited the exclusion of individuals with preexisting health conditions, 29 U.S.C. § 1181.

Since the establishment of Medicaid in 1965 and the passage of ERISA in 1974, the federal government has been actively involved in the regulation of the health insurance market. While the ACA represents an expansion of the federal government's presence, it is not a usurpation of an area traditionally left to state regulation alone.

d. Federal Intervention is Needed to Reform the Health Insurance Market.

Because of the national scope of healthcare and its importance to the national economy, States are unable to solve the problem of the uninsured [*24] without the assistance of the federal government. Most people obtain their healthcare through their employers, and States' attempts to reform the healthcare market come at great risk: a state's requirement that employers offer health insurance could lead to businesses moving to other States. Similarly, the regulation of insurance practices by a single State may make insurance companies reluctant to offer policies there. That is an especially powerful concern when a single insurance company provides coverage for the majority of individuals in a State, such as in Alabama, where the largest carrier has a 96% market share.[13] Moreover, a State that offered especially generous benefits could see individuals move to that State to take advantage of those benefits, increasing the State's financial burden. When Congress regulates the insurance industry on a national basis, these problems are greatly reduced.

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

Similar motivations caused Congress to regulate the labor market in the early 20th century. The Supreme Court initially determined that such efforts were outside Congress's Commerce Clause powers in a series of decisions that have since been discredited. *See, e.g., Bailey v. Drexel* [*25] *Furniture Co*, 259 U.S. 20 (1922) (invalidating congressional efforts to regulate child labor). The Court ultimately recognized that interstate competition would render efforts by individual States inadequate, and that national standards were needed. *United States v. Darby*, 312 U.S. 100, 122–23 (1941). Like decisions invalidating Congress's attempts to reform labor practices, arguments that the minimum coverage provision are not within Congress's Commerce Clause powers represent a myopic view of that authority.

States' efforts to regulate the health insurance market illustrate the need for congressional action. Maryland, like many states, has undertaken substantial efforts to address these problems, and it has made significant gains. In 2008, Maryland dramatically expanded its Medicaid program, raising the eligibility ceiling for parents and caretakers of dependent children from 30% to 116% of the federal poverty level. As a result of this expansion, the State's Medicaid program now provides coverage to approximately 74,000 Marylanders who would otherwise lack insurance. In 2002, the State created the Maryland Health Insurance Plan (MHIP), which provides coverage to Marylanders who are ineligible for Medicare or Medicaid and who have been deemed medically uninsurable by private [*26] carriers. Today, MHIP insures about 20,000 Maryland residents who would be assured of access to health insurance under the ACA starting in 2014.

While Maryland's efforts have been beneficial, these programs have come at a high cost, and have only reduced, not removed, the barriers to affordable care. Despite the State's expansion of its Medicaid program and its introduction of MHIP, 16.1% of Marylanders still lack health insurance, similar to the figure for the country as a whole. In 2009, the State's hospitals provided $999 million in uncompensated care to those without insurance. Moreover, the expansion of Maryland's Medicaid program to a substantial number of

additional low-income parents is expected to cost the State $498 million in the 2012 fiscal year. To provide benefits to MHIP's high-risk pool of enrollees, MHIP charges premiums substantially higher than those charged in the private market, and, in addition, the State imposes a 0.8% assessment on the net patient revenues of all Maryland hospitals to support MHIP. In the face of unexpectedly high demand for coverage and the high cost of claims, MHIP was forced, between 2006 and 2010, to increase premiums by about 40% for most of its membership and to institute new benefit caps and to lower existing ones. Notwithstanding the Plan's objective to provide insurance for otherwise uninsurable individuals, in 2007 MHIP was compelled to begin excluding coverage for benefits for [*27] preexisting conditions during the first six months of an enrollee's participation in the Plan.

Maryland's efforts illustrate the limits of States' ability to grapple with the national healthcare crisis, and the role that cooperative federalism can play in helping States increase their citizens' access to affordable health insurance. The ACA provides additional funds for Maryland to expand its Medicaid program, and allows for waivers should Maryland, or any other State, seek to do more. The ACA's prohibition on insurance companies' practice of excluding individuals with preexisting conditions reduces the need for MHIP and for the surcharge hospitals pay to support the Plan.

e. Upholding the Minimum Coverage Provision Will Not Provide the Federal Government with a General Police Power.

Sustaining the power of Congress to require individuals to maintain adequate health insurance would not give the federal government a general police power. First, existing precedent provides constraints on congressional power that preclude Congress from exercising a national police power now and in the future. Regardless of whether the authority to enact the minimum coverage provision is found in the Commerce Clause or the Necessary and Proper Clause, a decision sustaining its constitutionality would be based on the fact that the provision either directly affects interstate com-

merce or that [*28] it is *necessary* to support such a direct regulation. A ruling that acknowledges this direct link to interstate commerce poses no risk that the federal government will occupy traditional areas of authority reserved to the States.

Second, in advancing the "slippery slope" argument, Virginia seeks a decision striking down an existing, validly-enacted statute on the basis of the possible future enactment of an unconstitutional statute. This is not a valid basis for challenging the *ACA's* constitutionality. The mere potential that Congress could attempt to enact an unconstitutional law in the future is an insufficient reason to invalidate the ACA today. Frederick Schauer, *Slippery Slopes*, 99 Harv. L. Rev. 361 (1985).

Third, for all of the controversy surrounding the ACA, it is not fundamentally different from other federal programs that have been in existence for decades. The federal government has helped provide access to health insurance for large segments of the population through Medicare and Medicaid. It has regulated the provision of healthcare through employer-sponsored plans through ERISA, which governs how most Americans obtain health insurance. The ACA is conceptually no different from Social Security, which is in effect a federally-required retirement-insurance program. In both instances, Congress requires payment over time to avoid [*29] the social and economic costs of individuals who are unable or unwilling to prepare for retirement or for a catastrophic illness.

Indeed, the Social Security Act was also challenged as an incursion on States' prerogatives.[14] The Supreme Court's rejection of that argument is so compelling in the context of the debate over the ACA that it bears repeating:

> The problem is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it ef-

[14] Congress also possesses the authority to enact the minimum coverage provision under Congress's taxing power: only taxpayers are subject to the tax penalty imposed for failure to maintain a minimum level of coverage; the penalty is calculated by reference to an individual's income and is included in that individuals' tax return; the IRS collects the penalty and enforces the minimum coverage provision; and the $4 billion in projected annual revenues are used to fund other provisions of the ACA. *Cf. Sozninsky v. United States*, 300 U.S. 506 (1937); *United States v. Sanchez*, 340 U.S. 42, 44 (1950).

> fectively. Congress, at least, had a basis for that belief. States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged. . . . Apart from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors. . . . A system of old age pensions has special dangers of its own, if put in force in one state and rejected in another. The existence of such a system is a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose. Only a power that is national can serve the interests of all. [*30]

Helvering v. Davis, 301 U.S. 619, 644 (1937). The same thing could be said of the healthcare crisis currently gripping the States and the nation. The ACA no more intrudes on state sovereignty than did the Social Security Act.

As States, Amici are fiercely protective of their sovereignty, and have a vital role in ensuring that the balance of power between the state and federal governments reflected in the Constitution is rigidly maintained. The ACA does nothing to disturb that balance. Rather, it provides States with the necessary tools to ensure that their citizens have access to affordable medical care in a healthcare market that is truly national in scope.

II. THE MINIMUM COVERAGE PROVISION IS SEVERABLE FROM THE REMAINDER OF THE AFFORDABLE CARE ACT[15]

For the reasons set forth above, Amici strongly believe that the minimum coverage provision is well within Congress's powers under the Commerce Clause, and that it does not interfere with traditional areas of State sovereignty. Should this Court conclude that Congress lacked authority to enact the minimum coverage provision, however, it should affirm the decision of the district court severing that provision and provisions making reference to it from the

[15] The arguments in this portion of the brief address the cross-appeal in No. 11-1058.

ACA. "The standard for determining the severability of an unconstitutional provision is well [*31] established: '[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a matter of law.'" *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010) (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976)). In making this determination, the Court must determine whether the remainder of the ACA is capable of functioning independently. *Alaska Airlines v. Brock*, 480 U.S. 678, 684 (1987).

Although the ban on denying coverage based on a preexisting condition is dependent on the minimum coverage provision, the vast majority of the ACA can function as intended by Congress without it. California has taken a lead in implementing many of these provisions even before the minimum coverage provision takes effect in 2014, showing that these provisions, and many others, can operate independently. For instance, California has enacted legislation implementing the ACA's ban on denying coverage of children based on preexisting conditions, as well as its requirement that insurance plans cover dependent children who are 25 or under. 2010 Cal. Stat., Ch. 656 and 660. California has also passed legislation that prohibits a person's health insurance policyholder from canceling insurance once the enrollee is covered unless there is a [*32] demonstration of fraud or intentional misrepresentation of material fact. 2010 Cal. Stat., Ch. 658.

The ACA contains numerous provisions aimed at improving the quality of healthcare that do not depend on the minimum coverage provision. For instance, Title V of the ACA provides new incentives to expand the number of primary care doctors, nurses, and physician assistants through scholarships and loan repayment programs. Title IV of the ACA, on the other hand, contains provisions aimed at preventing illness in the first instance. It requires insurance companies to offer certain preventive services, and authorizes $15 billion for a new Prevention and Public Health Fund, which will support initiatives from smoking cessation to fighting obesity. 42 U.S.C. § 300u-11. The ACA also includes $4 billion in funding for two pro-

grams aimed at moving Medicaid beneficiaries out of institutions and into their own homes or other community settings.[16] One of these programs was enacted during George W. Bush's presidency, and was reauthorized by the ACA. ACA § 2403. Recently, the Department of Health and Human Services announced the first round of grants totaling [*33] $621 million, including over $22 million allocated to West Virginia.[17] Since this program was in effect before the ACA was enacted, it can clearly exist independently of the minimum coverage provision.

Finally, the ACA contains important consumer protections that will assist Amici in their duty to protect individuals from abusive practices of insurance companies. In addition to barring the practice of insurance companies rescinding coverage, the ACA allows consumers to appeal coverage determinations, and establishes an external review process to examine those decisions. California has already implemented a provision that expands consumer assistance programs and has received $3.4 million to enhance the capacity of existing consumer assistance networks and to provide assistance with filing complaints and/or appeals of adverse coverage decisions.[18] California has also received a $1 million grant to implement a provision of the ACA that grants States the authority to review premium increases. Each of these provisions is completely independent of the minimum coverage provision, as the district court recognized. Accordingly, [*34] should this Court invalidate the minimum coverage provision, it should leave the vast majority of the ACA intact.

CONCLUSION

The decision of the district court should be reversed.

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[16] http://www.hhs.gov/news/press/2011pres/02/20110222b.html (last accessed Feb. 27, 2011).

[17] *See* note 15.

[18] http://www.healthcare.ca.gov/Priorities/ImproveQualityandSecurityofPrivateInsurance.aspx (last accessed Feb. 27, 2011).

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Respectfully submitted,
KAMALA D. HARRIS
Attorney General of California
MANUEL M. MEDEIROS
State Solicitor General
TRAVIS LEBLANC
Special Assistant Attorney General

S/ Daniel J. Powell

DANIEL J. POWELL
Deputy Attorney General
Attorneys for Amici Curiae
State of California