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**DATE:** January 20, 2012  
**SUBJECT:** Amicus Brief Filed on Affordable Care Act

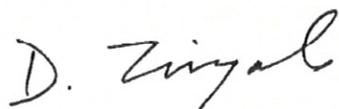
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Attached you will find a press release regarding The California Endowment's recently filed amicus brief and a copy of the brief filed with the Supreme Court on January 13, 2012. The amicus brief was filed in response to a recent Supreme Court decision to hear oral argument for a federal court case challenging the Minimum Coverage Requirement (MCR) of the Affordable Care Act.

The California Endowment's amicus brief offers supportive arguments for the constitutionality of the MCR through both the Commerce and The Necessary and Proper Clauses of the U.S. Constitution. As one of the largest health foundations in the nation, The California Endowment felt that our wealth of research and depth of knowledge from California should be shared with the Supreme Court as they contemplate their decision regarding the MCR.

The MCR is an essential component to successfully implementing the Affordable Care Act and recent data *indicates that an additional 1 million Californians will remain uninsured* if the MCR is ruled unconstitutional. We hope you will take the time to review the attached press release and amicus brief.

If you have any questions please contact Richard Figueroa, Program Director of Health and Human Services at The California Endowment, at (916) 558-6760.







FOR IMMEDIATE RELEASE  
January 13, 2012

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## THE CALIFORNIA ENDOWMENT FILES SECOND BRIEF IN U.S. SUPREME COURT

*Endowment Counsel, Preeminent Supreme Court Litigator  
Kathleen M. Sullivan Makes Compelling Arguments in Favor of  
the Constitutionality of the Affordable Care Act*

CUTTING-EDGE DATA IN THE ENDOWMENT'S BRIEF DEMONSTRATES THE ESSENTIAL NATURE  
OF THE MINIMUM COVERAGE REQUIREMENT TO THE ACT AS A WHOLE AND ITS  
IMPORTANCE TO GREATER ACCESS TO INSURANCE COVERAGE IN CALIFORNIA

*\*\*Read The California Endowment's FULL Amicus Brief To SCOTUS [HERE](#)\*\**

LOS ANGELES, Calif. – Today, The California Endowment, by way of esteemed Supreme Court litigator Kathleen M. Sullivan, filed a 'friend of the court' brief to the United States Supreme Court in strong support of the constitutionality of the Affordable Care Act, the new federal health care law. The Supreme Court recently agreed to hear oral arguments in late March 2012 for one of the many federal court challenges to the Affordable Care Act ("ACA"), *Department of Health & Human Services v. Florida et al.* (No. 11-398).

The California Endowment's amicus brief presents the Court with additional arguments in favor of concluding that the Minimum Coverage Requirement ("MCR") of the ACA is fully within Congress's authority under the Commerce and Necessary and Proper Clauses of the United States Constitution. The brief explains how the MCR has a real and tangible link to interstate commerce, and is a correction to market failure.

The California Endowment's brief highlights new data that shows how nearly 1.4 million Californians will remain uninsured if the Supreme Court determines the MCR unconstitutional.

The California Endowment is a major health foundation in the nation's most populous state with the highest number of uninsured. "Our mission to expand affordable care is in line with the Affordable Care Act and we felt it was imperative to share the tremendous



amount of research and data that can help inform the Court in ruling on the constitutionality of the law,” said Dr. Robert K. Ross, M.D. president and CEO of The Endowment. “We are excited to share new data that illustrates how the new health law will positively impact the health of communities in our state.”

The filing was prepared by The California Endowment counsel Kathleen M. Sullivan, one of the nation’s preeminent appellate litigators at Quinn Emanuel Urquhart & Sullivan, LLP.

“In this case the Supreme Court will decide whether Congress had the power to decide that the minimum coverage requirement is essential to reducing the number of the uninsured and reducing spiraling health care costs. The California Endowment’s brief provides powerful empirical evidence from California that strongly supports Congress’s authority,” said Ms. Sullivan. “With the MCR, the ACA will expand health insurance coverage to nearly two million non-elderly California citizens who are currently uninsured. Without the MCR, 1 million fewer California citizens will obtain health insurance under the ACA. In other words, without the MCR, the ACA will be 54 percent less effective in expanding health insurance to California citizens.”

- **Read The California Endowment’s FULL Supreme Court Amicus Brief**  
**HERE:** [http://www.calendow.org/uploadedFiles/No.%2011-398%20Amicus%20Proof%20\(Quinn%20Emanuel\).pdf](http://www.calendow.org/uploadedFiles/No.%2011-398%20Amicus%20Proof%20(Quinn%20Emanuel).pdf).
- **Read The New UCLA Policy Brief Referenced in TCE’s Amicus** **HERE:**  
[http://www.healthpolicy.ucla.edu/pubs/files/calsim\\_mandate.pdf](http://www.healthpolicy.ucla.edu/pubs/files/calsim_mandate.pdf).

###

**The California Endowment**, a private, statewide health foundation, was established in 1996 to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. Headquartered in downtown Los Angeles, The Endowment has regional offices in Sacramento, Oakland, Fresno and San Diego, with program staff working throughout the state. The Endowment challenges the conventional wisdom that medical settings and individual choices are solely responsible for people's health. The Endowment believes that health happens in neighborhoods, schools, and with prevention. For more information, visit The California Endowment’s homepage at [www.calendow.org](http://www.calendow.org).



No. 11-398

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IN THE  
**Supreme Court of the United States**

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

v.

FLORIDA, *et al.*,  
*Respondents.*

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

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

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

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**INTEREST OF *AMICUS CURIAE*<sup>1</sup>**

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

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

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

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

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

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

### **SUMMARY OF ARGUMENT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>5</sup> *Id.*

regulating that activity will be sustained.” (quoting *Morrison*, 529 U.S. at 610)). Whether considered “activity” or “inactivity,” “[t]he aggregate effect of that behavior ... is just as injurious to interstate commerce.” *Seven-Sky v. Holder*, 661 F.3d 1, 19 (D.C. Cir. 2011) (Silberman, J.).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>13</sup> Mendez, *supra* n.12.

<sup>14</sup> Harbage & Nichols, *supra*, n.8, at 2.

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

<sup>16</sup> *Id.*

<sup>17</sup> Cal. Hosp. Ass’n, *supra* n.8, at 3.

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

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

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

<sup>19</sup> Harbage & Nichols, *supra* n.8, at 2.

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

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

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

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<sup>21</sup> *Id.* at 7.

<sup>22</sup> Harbage & Nichols, *supra* n.8, at 2.

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

<sup>24</sup> Kominski & Roby *et al.*, *supra* n.4, at 2 & ex.1.

<sup>25</sup> *Id.*

<sup>26</sup> *Id.* at 2.

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

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

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

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

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

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

judgment) (citing *Lopez*, 514 U.S. at 561); accord *Comstock*, 130 S. Ct. at 1956 (“[T]he Necessary and Proper Clause makes clear that the Constitution’s grants of specific federal legislative authority are accompanied by broad power to enact laws that are ‘convenient, or useful’ or ‘conducive’ to the authority’s ‘beneficial exercise.’” (quoting *McCulloch*, 17 U.S. at 413, 418)).

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

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

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<sup>28</sup> See Kominski & Roby *et al.*, *supra* n.4, at 2-3 & ex.1.

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

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

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

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

<sup>30</sup> Kominski & Roby *et al.*, *supra* n.4, at 2 & ex.1. Massachusetts’ experience with a requirement to purchase insurance

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

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

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

<sup>31</sup> Kominski & Roby *et al.*, *supra* n.4, at 3.

<sup>32</sup> *Id.*

<sup>33</sup> Gruber, *supra* n.27, at 3.

**CONCLUSION**

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

Respectfully submitted,

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# Forbes

Scott Harrington, Contributor

Washington

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## Low enrollment but high costs for Pre-Existing Condition Insurance Plans

The Department of Health and Human Services (HHS) reported in January that as of November 11, 2011 there were 44,852 people enrolled in state-level Pre-Existing Condition Insurance Plans (PCIPs) created by the Affordable Care Act (ACA), up from 8,011 a year earlier. The Centers for Medicare & Medicaid Services had predicted PCIP enrollment of 375,000 by year-end 2010; the Congressional Budget Office had predicted average annual enrollment of 200,000 and much larger enrollment with greater funding. While enrollment remains much lower than projected, the average cost of medical claims per enrollee in some states has been much higher than anticipated, leading a number of states to request greater allocations of funds from the program.

PCIPs must accept applicants with specified pre-existing conditions who have been uninsured for at least six months at “a standard rate for a standard population” in the state. Twenty-seven states chose to administer their own PCIPs; plans in the remaining states and D.C. are administered by the federal government through a non-profit private contractor.

California had the largest enrollment with 4,907 enrollees through November (growing to 6,672 at year-end according to its plan administrators). Pennsylvania had 4,379, Texas 3,644, and Florida 3,285. Indiana, Michigan, New Jersey, Virginia, and Wisconsin had between 500 and 1,000 enrollees. Twenty-two states besides Massachusetts and Vermont (with special systems) and D.C. had fewer than 500.

Federal expenditures for PCIPs totaled \$386 million through September 30, 2011 (the latest expenditure data reported by HHS, representing 12 or more months of experience in almost all states). The ACA authorized \$5 billion for the program through its expiration on January 1, 2014, when the individual mandate, health insurance exchanges, and prohibitions on premiums and coverage decisions based on health status are scheduled to commence.

HHS announced last May that it would reduce premiums in federally administered plans by an average of 25 percent to spur enrollment based on revised specifications of “standard rates” in different states. It explained that state administered plans could seek lower rates by benchmarking against rates offered by large insurers or the largest insurer in a state, or by compressing rates for older compared with younger applicants. Some plans subsequently reduced rates significantly. Other actions to spur enrollment included expanded coverage

options, relaxed federal plan eligibility requirements to be more consistent with most states' requirements, increased promotion and marketing, and, beginning in the fall, paying fees to agents and brokers who refer applicants to either federal or state plans.

HHS reported medical claims, administrative expenses, and premiums of \$446 million, \$42 million, and \$102 million, respectively, for all plans combined through September, 2011. Premiums received equaled 23 percent of medical claims paid.

High medical costs compared with premiums have led to funding and capacity issues in some states, most notably California. HHS initially allocated the \$5 billion among states "using a combination of factors including nonelderly population, nonelderly uninsured, and geographic cost." Nine states have requested increases in their federal allotments to avoid capping enrollment. HHS increased allotments for California and New Hampshire; the other requests (Alaska, Colorado, Montana, New Mexico, Oregon, South Dakota, and Utah) are pending.

California administrators initially estimated that the state's \$761 million allotment of federal funding through 2013 would allow enrollment of 23,000 people, based on projected per enrollee medical costs of \$1,100 per month. The plan requested and received permission from HHS to reduce its rates by 18 percent effective August, 2011. Yet medical claims have averaged \$3,100 per enrollee per month, reducing to 6,800 the projected enrollment that could be financed by the state's initial allotment. HHS has authorized a \$118 million increase. New Hampshire, with 281 enrollees as of November 30, received an increase from \$20 million to \$50 million.

The implications of the PCIPs' early experience are uncertain. The low overall enrollment versus earlier projections implies that premiums, while far below medical costs, remain higher than many uninsured people with pre-existing conditions are willing to pay. Such people are not uninsured as a result of private insurers' health-based pricing and underwriting – they forego coverage even at "standard" rates calculated by state and federal administrators eager to increase enrollment. Low overall enrollment also might imply that there are many fewer uninsured people with costly to insure health conditions than previously assumed. That by itself could be good news for premiums under the ACA, or for funding expanded high risk pools as part of market-oriented reforms to replace the ACA.

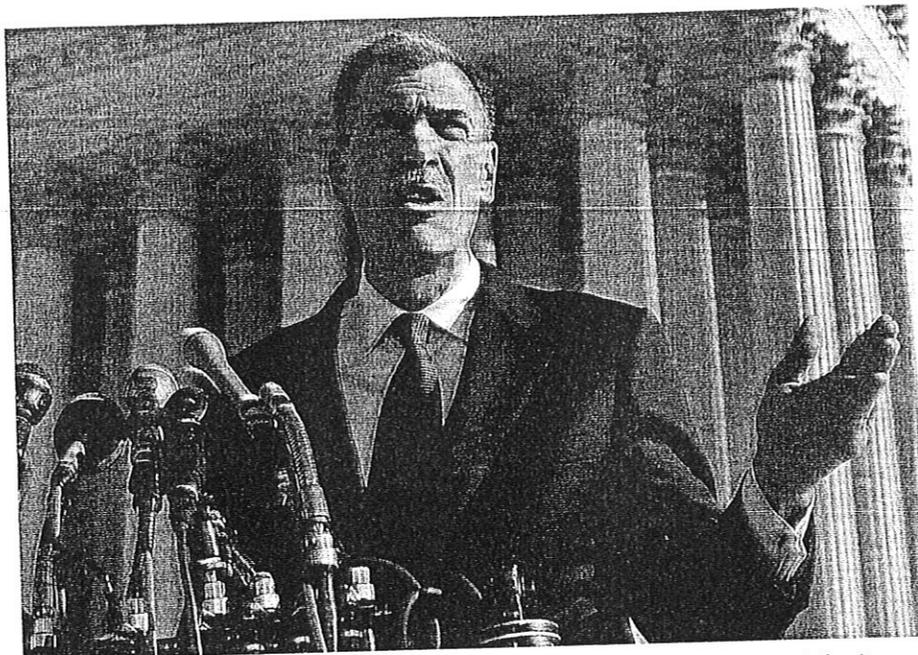
On the other hand, high average medical costs for PCIP enrollees in California and some other states add to potential concerns that a disproportionate number of people with very high medical costs would obtain coverage in 2014 and later years under the ACA's guaranteed issue and rating rules. That would put upward pressure on average premiums and cause greater numbers of healthier people to defer buying coverage until they needed costly care. The high medical costs in some PCIPs could also portend higher costs of funding expanded high risk pools as part of market-oriented reforms.

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This article is available online at:

<http://www.forbes.com/sites/scottharrington/2012/02/08/low-enrollment-but-high-costs-for-pre-existing-condition-insurance-plans/>

# ENTRY POINT



Donald B. Verrilli Jr., solicitor general of the United States, will take the lead in defending the Affordable Care Act for the Obama administration before the Supreme Court.

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## Health Reform Gets Its Day In Court—The Supreme One

*Justices could leave the Affordable Care Act intact, in shambles, or somewhere in between—and just months before the 2012 presidential election.*

BY T.R. GOLDMAN

**T**he Supreme Court's impending review of the Affordable Care Act of 2010 could be one of the most explosive Supreme Court cases in years—or one of the most anticlimactic.

Whatever the result, the high court's commitment to filling its entire court calendar with arguments about the law during the week of March 26, 2012, constitutes an extraordinary event. With five and a half hours of arguments over three

days, the hearing will be one of the Court's longest in decades. And with the Court's decision expected in late June—just four months before the 2012 national elections—the nine justices will be thrust into the middle of a divisive debate over what is arguably President Barack Obama's signature legislative achievement.

Given the vagaries of an election year, it is impossible to predict which party might benefit from a decision to uphold or strike down the law—although such is

the potential import of the case that it could tip the election results in either direction. "It's unusual both legally and in its political context," observes Stephen Wermiel, a law professor at American University who follows the Court closely. The case is expected to be among the most heavily lobbied on record, with a host of op-eds and television ads trying—no doubt unsuccessfully—to push the Court in one direction or the other.

The case is politicized in other ways as well. Innumerable "friend of the court" briefs will be filed on both sides of the issue. There have been repeated calls for two of the justices, Clarence Thomas and Elena Kagan, to recuse themselves—Thomas because his wife, Virginia, has close ties to conservative groups lobbying against the law and Kagan because she was US solicitor general while the health care law was enacted and legal strategies to defend it were being discussed. Neither justice is expected to ask for a recusal, however.

Many scholars believe that it's likely that the Court will deliver a weighty Constitutional pronouncement that redefines the boundaries of congressional authority. But at the other extreme, it is also possible that the nine justices will render nothing more than a prosaic and hypertechnical tax decision.

If so, that decision would hinge on the meaning of the word *penalty* in connection with the requirement that most Americans have health insurance starting in January 2014 or pay a penalty administered by the Internal Revenue Service. Less likely, but still possible, is an even more profound decision that could effectively reorient the federal government's long-standing relationship with the states.

"The court strikes down acts of Congress periodically, but many times the acts of Congress are relatively trivial," notes Nicholas Quinn Rosenkranz, a professor at the Georgetown University Law Center. "But this is landmark legislation that is potentially at stake, and for the Court to strike it down would be a huge deal. And the complications

for the scope of the commerce clause are kind of amazing.”

## Decisions

The Court could issue any of a range of possible decisions because it agreed to hear four very different questions concerning the Affordable Care Act. Perhaps the question that lies closest to the heart of the law is the legality of its individual mandate or “minimum coverage requirement.” But the Court will also hear arguments involving three related issues, including a key prefatory question that must first be resolved if the justices are to move forward and rule on the mandate.

That question involves a 145-year-old law known as the Anti-Injunction Act, which bars lawsuits against taxes that have not yet been levied. Under the Affordable Care Act, the Internal Revenue Service will not penalize anyone for failing to buy health insurance until 2015. As a result, if the justices believe that the law’s “penalty” is actually a “tax,” the Anti-Injunction Act will apply, and the Court will have to wait until 2015 or later to decide the actual merits of the case.

Only if the justices first agree that the Anti-Injunction Act does not apply in this case can the Court determine whether Congress overstepped its Constitutional authority by mandating the purchase of health insurance. If the Court declares the law unconstitutional, it then has an additional question to answer: Can the individual mandate be stripped from the Affordable Care Act without killing the entire law (a legal concept known as “severability”)?

The Obama administration argues that without the mandate, most of the rest of the law is severable, and only two components would have to go: the community-rating provision that bans insurers from pricing premiums based on a person’s health status, and the concept of “guaranteed issue,” which requires insurers to offer coverage to anyone who wants it, including people with preexisting conditions. But at least one federal judge, Roger Vinson of Florida’s Northern District, not only found the mandate unconstitutional but determined that it was not severable from the rest of the law. Consequently, he ruled that the entire law was invalid.

Finally, in a move that caught Court

watchers by surprise, the justices also agreed to examine a provision of the law related to federal funding for the expansion of Medicaid eligibility in 2014 and beyond. Under the law, the federal government will pick up 100 percent of the cost of providing coverage for those who become newly qualified for Medicaid between 2014 and 2016. After that, federal funding will gradually decline until 2020, and thereafter the federal share will be 90 percent. But the federal funding is “conditional”—that is, it flows to the states only if they agree to the Medicaid expansion. Florida and twenty-five other states argued that this conditional funding mechanism was unduly coercive, and the Court has agreed to hear those arguments.

But Medicaid has existed for forty-six years, and there have been numerous expansions, none of which has ever been invalidated, counters Families USA chief Ron Pollack. The best explanation for why the Court decided to take up the Medicaid issue, say legal experts, is that with twenty-six states as plaintiffs, it felt compelled to listen.

It’s also possible that the Court’s four liberal justices wanted to revisit a 1987 highway funding case known as *South Dakota v. Dole*. In that case, South Dakota challenged Congress’s threat to withhold federal highway funds from states whose legal drinking age was lower than twenty-one. The Supreme Court upheld lower-court decisions that sided with the federal government, but the case left unanswered some lingering questions on conditional federal funding that the liberal justices may hope to lay to rest now.

Given these four questions, the justices could fall back on the Anti-Injunction Act and avoid making a decision until the mandate and penalties go into effect. They could also uphold the entire law, an outcome that many legal experts believe is the most likely. Alternatively, they could strike it down altogether or declare only the individual mandate and one or two related provisions unconstitutional. Or they could render a muddy stew of partial dissents and partial concurrences, “a fractured decision with no effect or a highly uncertain effect,” says Wake Forest law professor Mark Hall.

## Challenges

The arguments before the Supreme Court in March will mark the final phase of a series of lawsuits that began immediately after the Affordable Care Act was signed into law on March 23, 2010. The first legal challenge, in the case that has now reached the Supreme Court, was led by the Florida attorney general and was eventually joined by twenty-five other states and the National Federation of Independent Business. It was filed at the federal court in Pensacola just a few hours after the act’s signing ceremony at the White House.

More than two dozen lawsuits were ultimately filed in states across the country, although many were dismissed because of procedural problems or because judges ruled that the plaintiffs did not have standing to sue. Some of the cases, however, were allowed to proceed. Three federal district court judges—all of them appointed by Republican presidents—struck the law down, ruling that the individual mandate and its enforcement exceeded Congress’s enumerated powers under the Constitution to regulate commerce “among the several States” (known informally as the “commerce clause”).

By the fall of 2011, four of the country’s twelve federal circuit courts—the appellate rung just below the Supreme Court—had ruled on the case. The District of Columbia Circuit and the Sixth Circuit each upheld the law by votes of two to one. The Eleventh Circuit ruled two to one that the mandate was unconstitutional, while the Fourth Circuit said that the Anti-Injunction Act applied and that therefore the case could not yet be heard.

More significantly, two prominent conservative jurists—Jeffrey Sutton in the Sixth Circuit, a George W. Bush appointee, and Laurence Silberman in the D.C. Circuit, a Ronald Reagan appointee—both concluded that the mandate was constitutional. “Not every intrusive law is an unconstitutionally intrusive law,” Sutton wrote in his opinion. Then, on November 14, the Supreme Court announced that it would take up the case, in effect reviewing the decision of the Eleventh Circuit Court of Appeals.

## The Commerce Clause

For the March 2012 arguments, the Supreme Court has allotted two of the five and a half hours—the largest chunk of time given to any of the four questions—to the constitutionality of the individual mandate. The issue is of intense interest to legal scholars because of the linkage to the Constitution's commerce clause, as well as to the additional authority handed to the legislature under the "necessary and proper" clause. That second section allows Congress "to make all Laws which shall be necessary and proper for carrying into Execution the foregoing powers." Among those "foregoing" enumerated powers is the right to regulate commerce among the states.

The precise meaning of both clauses has been the subject of Supreme Court cases stretching back to *McCulloch v. Maryland* in 1819 and as recently as *Gonzales v. Raich* in 2005. But on a broader level, the interpretation of the two clauses also embodies two different conceptions of America: the federal government as a broad backstop to handle society's most pressing problems, and the federal government as having very few and very limited powers.

Supporters of the Affordable Care Act say the constitutionality of the mandate is self-evident, and they made sure to note that in the body of the law, health care makes up 17.6 percent of the country's gross domestic product—an inherently commercial function "among the several States" that Congress can therefore regulate. The mandate is the tool needed to carry out congressional efforts to contain spiraling health care costs, eliminate the uninsurability of people with preexisting medical conditions, and address the problem of the fifty million Americans who currently do not have health insurance.

It all sounds straightforward enough—until plaintiffs' lawyers start arguing over the meaning of *regulate* and *commerce* and *necessary and proper*. "If you've chosen not to buy something, you're not engaging in commerce," argues Ilya Somin, a law professor at George Mason University who has briefed the Washington Legal Foundation on the issue. "Not having health insurance is not commerce." Adds Michael Carvin, a Jones Day partner who represents one of the plaintiffs,

## Many legal scholars are betting that the court will uphold the law.

the National Federation of Independent Business: "In every commerce clause case since the dawn of time, it's been clear: If you don't have commerce, you can't regulate commerce."

### Activity/Inactivity

Supporters of the Affordable Care Act like to point to two seminal cases, *Wickard v. Filburn* in 1942 and *Gonzales v. Raich* in 2005, both of which reinforce the notion that Congress enjoys wide latitude under the commerce clause. In the first case, Roscoe Filburn sued the government after he exceeded a wheat quota set by the Department of Agriculture to prop up prices during the Depression.

Filburn argued that the extra wheat he had grown was intended only for his family and livestock, and because he did not plan to sell it, it would not have any impact on wheat prices. But the Supreme Court ruled unanimously that even if Filburn's activity was strictly local and there was no commercial intent, his decision still had a measurable impact on the interstate wheat market because Filburn no longer needed to buy wheat to feed his chickens.

In *Raich*, the Court ruled six to three that the commerce clause gave Congress authority to prohibit the local cultivation and use of marijuana despite a California law that allowed Angel Raich to use the drug for medicinal purposes. Antonin Scalia, one of the court's bedrock conservatives, voted with the majority.

In the past the Court has placed some limits on Congress's reach, most notably in *U.S. v. Lopez* in 1995 and *U.S. v. Morrison* in 2000. In those cases, the Court invalidated two federal statutes because they relied on the commerce clause to regulate noneconomic activity. But failing to purchase health insurance is economic activity, the US government now argues. People who don't pay for health insurance almost always end up in the health care system anyway, and most of the time they don't pay for all of their treatment. As the act itself

spells out, in 2008 some \$43 billion in uncompensated health care costs were passed to others in the form of higher premiums.

Judge Silberman of the D.C. Circuit particularly agreed with this point, and in his decision he made short shrift of the activity/inactivity argument: "We think Congress can also regulate instances of ostensible *inactivity* inside a state. The aggregate effect of that behavior, after all, is just as injurious to interstate commerce," he wrote.

Supporters of the law's constitutionality also believe they will be aided by another broad reading of the commerce clause in the 2010 case of *U.S. v. Comstock*. In that case, the Court ruled seven to two that Congress had the authority to pass a law authorizing the involuntary civil commitment of "sexually dangerous" people even after they had completed their federal prison sentence. Five of the justices, including Chief Justice John Roberts, signed onto the majority opinion that the "necessary and proper" clause gave Congress wide authority to enact legislation as long as it was "rationally related to the implementation of a constitutionally enumerated power."

### 'Not Fatal'

The government's biggest hurdle, however, is articulating a "limiting principle" for its contention that the individual mandate is constitutional—in other words, a principle that can be applied to future circumstances and that doesn't cede to Congress a seemingly excessive amount of power. This principle will have to go beyond a simple claim that health care is somehow "unique" and warrants this degree of power. After all, the argument goes, if Congress can mandate health insurance because everyone eventually needs health care, then why can't it mandate that people must eat broccoli because everyone is in the market for food?

For Silberman, this issue emerged as a "troubling, but not fatal" problem. Earlier, the issue had clearly weighed on the Eleventh Circuit's three-judge panel and doubtless affected its decision to strike the mandate down. "Ultimately, the government's struggle to articulate cognizable, judicially administrable limiting principles only reiterates the conclusion

we reach today: there are none," the court declared. Congress has a great deal of leeway under its commerce clause powers, the court added—but what it "cannot do under the Commerce Clause is mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die."

Many legal scholars are betting that the court will vote to uphold the law with anywhere from a five-to-four to an eight-to-one majority. In the latter case, Justice Clarence Thomas is likely to be the sole holdout. "If you look at conservative thought in America, there are multiple ideas, some of which would support the idea [that the Affordable Care Act] is unconstitutional, others that it's not," says Yale Law School professor Jack Balkin. "Silberman is a very conservative judge—nobody will get to the right of him—but his view of what it means to be a conservative judge is to respect majority decision making and defer to Congress on majoritarian votes."

### Tax?

First, however, the justices have to determine that the Anti-Injunction Act, which bars challenges to federal tax provisions until they actually take effect, does not apply in the case of the Affordable Care Act. A central issue in this discussion is whether or not the individual mandate is a tax and therefore covered by the Anti-Injunction Act.

Silberman, noting that the fine for failing to purchase health insurance is called a "penalty" and that the penalty's goal is "universal coverage, not revenues from penalties," ruled that the mandate's prescribed penalty is not a tax. However, his younger colleague on the D.C. Circuit, Brett Kavanaugh, dissented with a sixty-five-page analysis of the issue. "The Tax Code is never a walk in the park," he wrote, with some understatement.

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## A central issue is whether or not the individual mandate is a tax.

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ment. "But the statutory analysis here leads to a firm conclusion that the Anti-Injunction Act bars this suit."

Kavanaugh's reasoning was based on a close reading of highly technical provisions of federal tax law. The Affordable Care Act requires that the tax penalty for failing to maintain health insurance "be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68," Kavanaugh wrote. "And penalties under subchapter B of chapter 68 in turn must 'be assessed and collected in the same manner as taxes,'" he continued, italicizing the words for emphasis. "That straightforward chain of logic convincingly demonstrates that the Anti-Injunction Act poses a jurisdictional bar to our deciding this case."

Initially, the government began its defense of the Affordable Care Act in the lower courts by invoking the Anti-Injunction Act and arguing that the penalty for not complying with the individual mandate was a tax. But by the time the case reached the Supreme Court, neither side was arguing that the Anti-Injunction Act applied. "At first, like all good lawyers do, you want to get the case dismissed for any reason," says Hall, explaining the government's initial embrace of the argument. "But as they got further into it, it became more important to get [the constitutionality of] the law resolved."

Alan Morrison, a veteran Supreme Court lawyer, has written friend-of-the-court briefs on behalf of two former Internal Revenue Service commissioners, who also argue that the Anti-Injunction Act applies. He says it is difficult to pre-

dict how the justices will vote on the issue. "They may ride roughshod over it, or they might gladly seize upon it to stay out of a hot political question—or at least use it to postpone the question for a few years," he says. "Either one," he says, would be a "completely rational" response.

The three days of oral arguments coming in March will be carefully orchestrated. On Monday, March 26, the Court will hear an hour of argument on whether the Anti-Injunction Act stands in the way of challenges to the individual mandate. The next day, Tuesday, the Court will hear two hours of argument on the constitutionality of the individual mandate itself. And on Wednesday, the Court will hear ninety minutes of argument in the morning on the severability issue, followed by an hour in the afternoon on the Medicaid expansion.

Donald B. Verrilli Jr., Justice Kagan's successor as solicitor general of the United States, will take the lead in defending the Affordable Care Act for the Obama administration. Opposing him will be Paul D. Clement, a former solicitor general in the George W. Bush administration and a lawyer for the twenty-six states challenging the law. Because the original parties to the Eleventh Circuit case—the federal government and the twenty-six states and private parties—agreed with each other on the severability and Anti-Injunction Act issues, the Supreme Court invited two outside lawyers to argue on the other side.

Thus, what now lies ahead for March are three days of densely legal disagreements with enormous implications for public policy—the likes of which haven't been aired in Washington since the 2000 case of *Bush v. Gore*. ■

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# CHIPRA at Work Three Years Later: Shaping State Actions and Connecting Children to Coverage

## Introduction

**"Today, with one of the first bills I sign—reauthorizing the Children's Health Insurance Program—we fulfill one of the highest responsibilities we have: to ensure the health and well-being of our nation's children...In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation—health care for our children is one of those obligations."**

*—President Barack Obama, February 4, 2009, upon signing the Children's Health Insurance Reauthorization Act (CHIPRA) into law.*

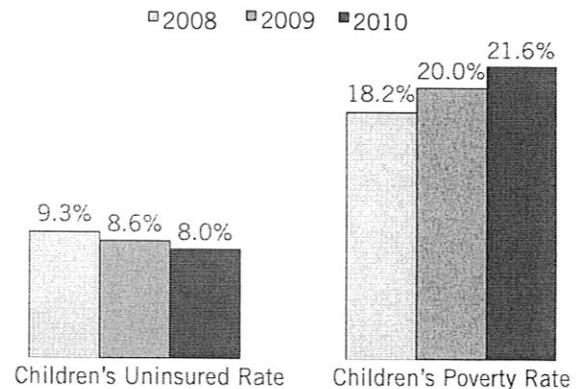
When President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) on February 4, 2009, the nation already was well into the worst recession since the Great Depression.<sup>1</sup> The recession severely shrank state revenues while boosting the need for Medicaid and CHIP as families lost jobs and their employer-based health insurance. On hand to witness that historic moment were Greg Secrest and his family from Martinsville, Virginia, who knew only all too well the impact of the recession. But they also knew first-hand what a relief CHIP could be for a family suffering through tough times when they secured coverage for their two sons through FAMIS, Virginia's CHIP plan.

"Making sure the boys are healthy and happy can make the rest of my family's problems seem small," said Mr. Secrest at the time. "Everything we have can be replaced with time and hard work, but they cannot."

Medicaid and CHIP are one of our country's greatest success stories, providing high quality health care for millions of children, like the Secrests, and peace of mind for their families. The enactment of CHIPRA three years ago amplified this success by giving states additional tools and resources to maintain and improve children's access to health care. At the time, no one knew that the

economic crisis would drag on for years, making it all the more important to provide health coverage to the nation's uninsured children. To a remarkable extent, Medicaid and CHIP have worked exactly as intended despite the unprecedented nature of the economic turmoil. Since 2008, the number of uninsured children has decreased by one million, even as their parents and other adults have grown more likely to join the ranks of the uninsured and child poverty has jumped to alarmingly high levels.<sup>2</sup>

**Figure 1. The uninsured rate of children has declined even as child poverty has jumped**



Source: American Community Survey, 2008-2010

The Affordable Care Act has played a significant role in this success story by requiring states to maintain Medicaid and CHIP eligibility and enrollment procedures. However, the country has gone well beyond simply holding steady when it comes to children's coverage—the uninsured rate of children is now at the lowest level on record. In a striking tribute to the effectiveness of CHIPRA, each and every state has benefited from one or more of the law's opportunities to advance coverage for children, with some going much further than others.

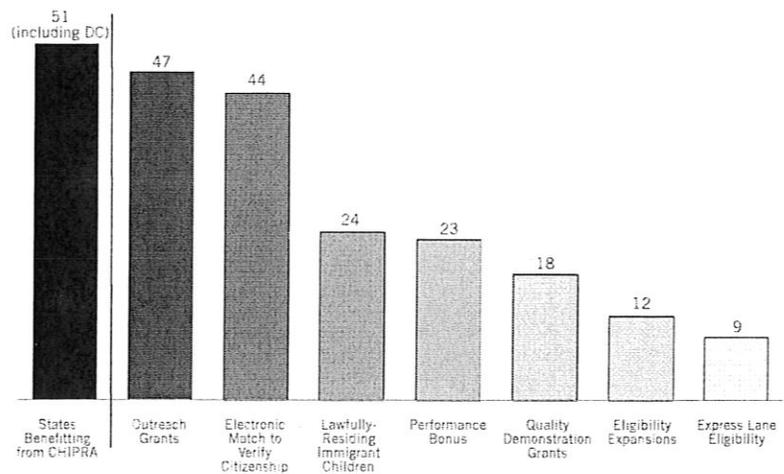
Without these actions, it is difficult to imagine that the country would have made major strides in covering its children in the midst of the worst recession in decades.<sup>3</sup>

The law put CHIP on a more secure financial footing, giving states the resources to sustain and strengthen their CHIP programs and to enroll more of the uninsured children who were already eligible for Medicaid, as well as CHIP.<sup>4</sup> In addition to extending and increasing funding for CHIP through 2013,<sup>5</sup> CHIPRA affirmed state flexibility to expand eligibility, introduced new opportunities to reduce paperwork and connect kids to coverage, created performance-based incentives for states to streamline application and renewal procedures and increase Medicaid enrollment, and launched initiatives to assess and improve the quality of health care for children. (See Appendix A for a state-by-state list of actions resulting from CHIPRA.)

### Building a Stronger Foundation; Extending Coverage to More Children

CHIPRA untied the hands of states to provide access to more families who are struggling to find affordable coverage for their children. Prior to CHIPRA, state expansion plans had been stymied due to the uncertainty of adequate federal funding for CHIP going forward and

Figure 2. Number of States Taking Advantage of CHIPRA Tools and Incentives



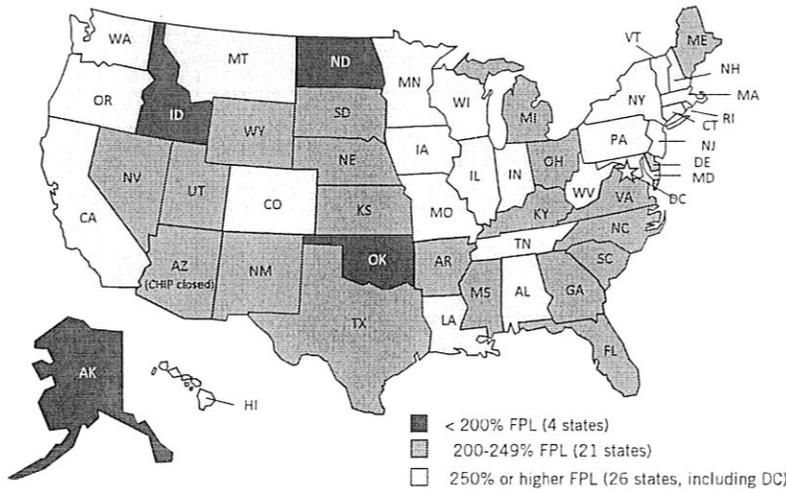
Note: Many states appear in more than one category • See Source Data in Appendix A

by efforts of the Bush administration to cap coverage at 250 percent of the federal poverty level (FPL) through executive order. Over the past three years, 12 states raised eligibility for uninsured children, resulting in a median coverage level of 250 percent of the FPL,<sup>6</sup> with higher income families generally paying a share of the cost of their children's coverage through premiums and/or co-payments. Expansions of eligibility often have an unexpectedly positive impact – even small ones create a welcome mat effect that fuels enrollment of children already eligible for both Medicaid and CHIP and leads to additional coverage gains.

Lawfully-residing immigrant children in 24 states are now eligible for Medicaid and CHIP after CHIPRA gave states the option to lift the five-year waiting period previously required before federal

funding could be tapped. As a direct result, lawfully-residing immigrant children gained access to coverage in eight (8) new states across the country.<sup>7</sup> In the remaining 16 states that have taken advantage of this CHIPRA option, federal funding bolstered existing state-funded programs for immigrant children, making such coverage less vulnerable to state budget cuts.<sup>8</sup>

Figure 3. Children's Eligibility for Medicaid/CHIP by Income, January 2012



Source: Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families.

## Lightening the Paperwork Load for Families and States

Appreciating the value of using technology to streamline enrollment and reduce state administrative burdens, CHIPRA gave states a new option to rely on an electronic data exchange with the Social Security Administration to verify citizenship. As a result, families in 44 states applying for Medicaid and CHIP no longer have to use a paperwork-intensive process to prove their citizenship status, a welcome relief for families and states alike.<sup>9</sup> States report extremely high rates of successful matches in confirming citizenship, as well as significant administrative cost savings.<sup>10</sup>

An impressive number of children – 10,484 – were enrolled in Medicaid in Louisiana in a single night on February 11, 2010, thanks to a new CHIPRA option called Express Lane eligibility. Following Louisiana's lead, eight (8) additional states are using the eligibility findings of other income-based programs such as the Supplemental Nutrition Assistance Program (SNAP) or accessing income data from the state revenue or tax department to enroll or renew coverage for tens of thousands of eligible, low-income children.

## Supporting and Rewarding State Enrollment Efforts

Acknowledging that the job of covering kids is not done, despite significant progress, CHIPRA invests in strategic and sustained outreach. CHIPRA has awarded \$90 million in 149 grants to community-based organizations, provider groups, multi-state consortiums, Indian health organizations, and state agencies in 47 states to conduct outreach and boost enrollment and retention. Tens of thousands of families have been enrolled as a result of these state and community-based outreach and enrollment activities.

To support state efforts to enroll and retain the lowest-income children, CHIPRA awards performance bonuses to states that simplify the way families apply for and renew coverage and exceed specific enrollment targets for children in Medicaid.<sup>11</sup> In 2011 alone, 23 states received bonuses for enrolling 1.2 million children beyond the law's aggressive enrollment goals, which increase markedly each year. The progression of states earning bonuses from 10 in 2009 to 16 in 2010 to 23 in 2011 illustrates that the

potential to earn a performance bonus is a strong motivator for states to take action. For example, Ohio expressly implemented 12-month continuous eligibility and presumptive eligibility in a matter of weeks in March 2010 to meet the April deadline to qualify for a 2010 bonus, while South Carolina implemented Express Lane eligibility in a similar fashion in 2011. Altogether over the past three years, states earned more than \$500 million in CHIPRA performance bonuses, helping to offset the state cost of covering more children and leading to increased participation of children already eligible for Medicaid and CHIP.<sup>12</sup>

Table 1. CHIPRA Performance Bonus Awards

	2009	2010	2011
Number of States Awarded Bonus	10	16	23
Range of Individual Awards	\$.7 million – \$9.5 million	\$.8 million – \$23.4 million	\$1.3 million – \$28.3 million
Total Amount Awarded	\$37.1 million	\$167.2 million	\$296.5 million

## Measuring and Assuring Quality Care for Children

CHIPRA recognizes that getting kids covered is only the first step. To ensure that access to coverage translates to access to care and better health outcomes, the law launched a variety of quality initiatives. Eighteen (18) states have received \$20 million in CHIPRA funding for 10 multi-year demonstration projects to strengthen the quality of care and serve as learning laboratories for all states. Additionally, a set of 24 core pediatric measures have been developed to assess and compare the quality of health care for children, along with a process to expand quality measurement and improvement activities over time.<sup>13</sup>

## Providing a Blueprint for Moving Forward

The reauthorization of CHIP continues to advance and improve children's coverage in far-reaching and fundamental ways. Every state and the District of Columbia have benefited, some more than others, from CHIPRA. The progress made and lessons learned in covering our nation's children provide a blueprint for the country as it implements more sweeping reforms to expand coverage to all of its lawful residents under the Affordable Care Act.

## Endnotes

- 1 According to the National Bureau of Economic Research, the recession officially began in December 2007 and ended in June 2009, <http://www.nber.org/cycles/sept2010.html>.
- 2 T. Mancini, M. Heberlein, and J. Alker, "Despite Economic Challenges, Progress Continues: Children's Health Insurance Coverage in the United States from 2008-2010, Georgetown Center for Children and Families (November 2011).
- 3 In prior recessions, the fiscal pressures propelled states to trim eligibility and tighten application and renewal procedures to suppress enrollment. See D. Cohen Ross, et al "Beneath the Surface Barriers Threaten to Slow Progress on Expanded Health Coverage of Children and Families: a 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2004," Kaiser Commission on Medicaid and the Uninsured (October 2004).
- 4 D. Horner, J. Guyer, C. Mann and J. Alker, "The Children's Health Insurance Program Reauthorization Act of 2009," Georgetown University Center for Children and Families (March 2009).
- 5 Congress subsequently extended funding for CHIP through 2015 in the Affordable Care Act.
- 6 The median eligibility level includes Illinois, where approval is pending to secure federal funding for children currently covered by state-only funds between 200 and 300 percent of the federal poverty level. See M. Heberlein, T. Brooks, J. Guyer, S. Artiga, J. Stephens, "Performing Under Pressure," Kaiser Commission on Medicaid and the Uninsured, (January 2012).
- 7 New states offering coverage to lawfully-residing children include IA, MT, NC, NM, OR, RI, VT, and WI. Rhode Island eliminated state-funded coverage for immigrant children in 2008 but reinstated it after CHIPRA provided critical federal support.
- 8 Pennsylvania also covers lawfully-residing children with state-only funds and has a state plan amendment pending with CMS to secure approval to cover these children. When approved, a total of 25 states will be covering lawfully-residing children through Medicaid and/or CHIP.
- 9 For a detailed description of the citizenship documentation requirement and the SSA verification option, see Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, "CHIP Tips: Citizenship Documentation Changes" (May 8, 2009).
- 10 California estimated savings of \$26 million annually by implementing the electronic data exchange with the SSA. For more information, see D. Cohen Ross, "New Citizenship Documentation Option for Medicaid and CHIP is Up an Running," The Center on Budget and Policy Priorities, (April 2010).
- 11 For a detailed description of the performance bonus provision, see Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, "CHIP Tips: Performance Bonus" and "CHIP Tips: Performance Bonus "5 of 8" Requirements" (June 4, 2009).
- 12 G. Kenney, V. Lynch, J. Haley, M. Huntress, D. Resnick and C. Coyer, "Gains for Children: Increased Participation in Medicaid and CHIP in 2009," The Urban Institute, (August 2011).
- 13 Department of Health and Human Services, "Children's Health Insurance Program Reauthorization Act, 2011 Annual Report: Quality of Care for Children in Medicaid and CHIP," (September 2011).

This brief was prepared by Tricia Brooks and Jocelyn Guyer of the Georgetown Center for Children and Families.

CCF is an independent, nonpartisan research and policy center based at Georgetown University's Health Policy Institute whose mission is to expand and improve health coverage for America's children and families.

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APPENDIX A  
States Taking Advantage of CHIPRA Tools and Resources

State	Eligibility Expansions Since CHIPRA <sup>1</sup>	Coverage for Lawfully-Residing Immigrant Children <sup>2</sup>	Express Lane Eligibility <sup>3</sup>	Social Security Administration (SSA) Data Match to Verify Citizenship <sup>4</sup>	Performance Bonus <sup>5</sup>	CHIPRA Quality Demonstration Grants <sup>6</sup>	CHIPRA Outreach Grants <sup>7</sup>
<b>Total</b>	<b>12</b>	<b>24</b>	<b>9</b>	<b>44</b>	<b>23</b>	<b>18</b>	<b>47</b>
Alabama	300%		Y	Y	2009,2010,2011		Y
Alaska				Y	2009,2010,2012	Y	Y
Arizona							Y
Arkansas				Y			Y
California		Y		Y			Y
Colorado	250%			Y	2010,2011	Y	Y
Connecticut		Y		Y	2011		Y
Delaware		Y		Y			
District of Columbia		Y		Y			Y
Florida						Y	Y
Georgia			Y	Y	2011	Y	Y
Hawaii		Y		Y			Y
Idaho				Y	2010,2011	Y	Y
Illinois		Y		Y	2009,2010,2011	Y	Y
Indiana							Y
Iowa	300%	Y	Y	Y	2010,2011		Y
Kansas	238%				2009,2010,2011		Y
Kentucky				Y			
Louisiana			Y	Y	2009,2010,2011		Y
Maine		Y		Y		Y	Y
Maryland		Y	Y	Y	2010,2011	Y	Y
Massachusetts		Y		Y		Y	Y
Michigan				Y	2009,2010,2011		Y
Minnesota		Y		Y			Y
Mississippi				Y			Y
Missouri							Y
Montana	250%	Y		Y	2011		Y
Nebraska	200%	Y		Y			Y
Nevada				Y			Y
New Hampshire				Y			Y
New Jersey		Y	Y	Y	2009,2010,2011		Y
New Mexico		Y		Y	2009,2010,2011	Y	Y
New York	400%	Y		Y			Y
North Carolina		Y		Y	2011	Y	Y
North Dakota	160%				2011		Y
Ohio				Y	2010,2011		Y
Oklahoma				Y			Y
Oregon	300%	Y	Y	Y	2009,2010,2011	Y	Y
Pennsylvania			Y	Y		Y	Y
Rhode Island		Y		Y			
South Carolina			Y	Y	2011	Y	Y
South Dakota				Y			Y
Tennessee				Y			Y
Texas		Y		Y			Y
Utah				Y		Y	Y
Vermont		Y				Y	
Virginia		Y		Y	2011		Y
Washington	300%	Y		Y	2009,2010,2011		Y
West Virginia	300%			Y		Y	Y
Wisconsin	300%	Y		Y	2010,2011		Y
Wyoming				Y		Y	Y

Source: M. Heberlein, T. Brooks, J. Guyer, S. Artiga, J. Stephens, "Performing Under Pressure," Kaiser Commission on Medicaid and the Uninsured, (January 2012); updated by the Center for Children and Families. Data as of January 1, 2012.

- States listed in this column have increased the income level at which families qualify for CHIP since CHIPRA was enacted in February 2009. The source for this analysis is the 2009 and 2012 Kaiser Commission on Medicaid and the Uninsured 50-State Surveys on Medicaid and CHIP Eligibility, Enrollment and Cost-Sharing Practices.
- This column indicates whether the state received approval through a State Plan Amendment to adopt the option to cover immigrant children who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option. Illinois (CHIP), Massachusetts (CHIP), and Pennsylvania are waiting for CMS approval. Pennsylvania currently covers these children with state-only funds. Virginia and North Carolina cover lawfully-residing children in Medicaid only.
- The Express Lane eligibility option allows states to use data and eligibility findings from other public benefit programs when determining children's eligibility for Medicaid and CHIP at enrollment or renewal. States are designated as using Express Lane eligibility if they have an approved State Plan Amendment from CMS.
- This CHIPRA option became newly available in 2010 and allows states to conduct data matches with the Social Security Administration to verify citizenship. States are listed if they are using the electronic data match in either Medicaid or CHIP.
- For more information on program features achieved by awardees and amounts of bonus payments, see [insurekidsnow.gov](http://insurekidsnow.gov).
- On February 22, 2010, CMS awarded \$20 million in CHIPRA Quality Demonstration Grants, which included four single-state and six multi-state projects. For a description of projects and partnerships, see: Department of Health and Human Services, "Children's Health Insurance Program Reauthorization Act, 2011 Annual Report: Quality of Care for Children in Medicaid and CHIP," (September 2011).
- On September 30, 2009, Cycle 1 of the CHIPRA Outreach Grants were awarded to 42 states and the District of Columbia. In April 2010, CHIPRA American Indian Alaska Native Grants were awarded to 41 Indian health providers in 19 states. On August 18, 2011, Cycle 2 CHIPRA Grants were awarded to 39 grantees in 23 states. For a list of project grantees and summaries, see [Medicaid.gov](http://Medicaid.gov).

## A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law

After the enactment of the Affordable Care Act (ACA) in March, 2010, numerous lawsuits challenging various provisions of the landmark health care reform law were filed in the federal courts. Many of those cases were dismissed, but some federal appellate courts issued decisions on the merits of the law. In November, 2011, the United States Supreme Court agreed to consider several issues related to the constitutionality of the ACA arising out of two cases in the 11<sup>th</sup> Circuit Court of Appeals, *National Federation of Independent Business v. Sebelius*,<sup>1</sup> and *Florida v. Department of Health and Human Services*.<sup>2</sup> This policy brief explains the issues raised by the cases pending before the Supreme Court, answers some key questions about the parties' legal arguments, and considers potential effects of the Court's decisions.

### Background

The Supreme Court will consider the constitutionality of two major provisions of the ACA: the individual mandate and the Medicaid expansion.<sup>3</sup>

#### *The Individual Mandate and Related Provisions*

The minimum essential coverage provision of the ACA, known as the individual mandate, requires most people to maintain a minimum level of health insurance coverage for themselves and their tax dependents in each month beginning in 2014. The individual mandate can be satisfied by obtaining coverage through employer-sponsored insurance, an individual insurance plan including those to be offered through the new health insurance exchanges, a grandfathered health plan, government-sponsored coverage such as Medicare or Medicaid, or similar federally recognized coverage. People exempt from the individual mandate include undocumented immigrants, religious objectors, and people who are incarcerated.

To increase access to affordable health insurance, the ACA provides for the creation of health insurance exchanges which will offer qualified health plans, as well as cost-sharing assistance to people with incomes between 100% and 250% of the federal poverty level (FPL) and premium tax credits to people with incomes between 133% and 400% FPL. The ACA also includes new private insurance market regulations, including the guaranteed-issue provision, which prevents health insurers from denying coverage to people for any reason, including pre-existing conditions, and the community-rating provision, which allows health plans to vary premiums based only on age, geographic area, tobacco use, and number of family members, thereby prohibiting plans from charging higher premiums based on health status or gender. The Congressional authors of the ACA believed that without the individual mandate, the exchanges and private insurance market reforms would not work effectively due to the adverse selection effect of healthy people choosing to forego insurance.

If a person does not satisfy the individual mandate, she will owe a financial penalty, known as the shared responsibility payment. The financial penalty will be a percentage of household income,

subject to a floor and capped at the price of the forgone insurance coverage, assessed and collected by the IRS and reported on federal income tax returns. Certain individuals are exempt from the financial penalty, including people for whom annual insurance premiums would exceed 8% of their household adjusted gross income, members of American Indian tribes, people who receive financial hardship waivers, people with incomes below the tax filing threshold, and people who lacked insurance for less than three months during a year.

### *The Medicaid Expansion*

The ACA also increases access to affordable health insurance by expanding eligibility for Medicaid benefits. The Medicaid program provides health insurance coverage to people with low incomes and is jointly funded by the federal and state governments. The program is voluntary for states: states are not required to participate, but all states currently do. If a state chooses to participate in the Medicaid program, there are a number of options that it can elect, but it must follow certain federal rules.<sup>4</sup> One of the federal requirements concerns the groups of people who must be covered by a state's Medicaid program. The mandatory coverage groups have been expanded by Congress several times since the program's enactment in 1965, and currently generally include pregnant women and children under age 6 with family incomes at or below 133% FPL, children ages 6 through 18 with family incomes at or below 100% FPL, adults who meet the financial eligibility requirements for the former AFDC (cash assistance) program, and people who qualify for Supplemental Security Income benefits based on low income and disability status. The ACA again expands the Medicaid program's mandatory coverage groups by requiring that participating states cover nearly all people under age 65 with household incomes at or below 133% FPL beginning in January, 2014. To fund this expansion of Medicaid coverage, the ACA provides that the federal government will cover 100% of the states' costs of the coverage expansion beginning in 2014, gradually decreasing to 90% in 2020 and thereafter. According to the Congressional Budget Office, the ACA's Medicaid expansion will cover an estimated 16 million uninsured, low-income Americans.<sup>5</sup>

### Key Questions

#### 1. Who are the parties in the cases accepted by the Supreme Court, and what do they want?

The Supreme Court has accepted issues from two cases filed in Florida, which have been consolidated. One case was filed by the National Federation of Independent Businesses (NFIB) and two individual plaintiffs who do not currently have health insurance (the private plaintiffs) against the federal government.<sup>6</sup> The NFIB and the individual plaintiffs' arguments center on the validity of the individual mandate. The private plaintiffs argue that the individual mandate is not a valid exercise of Congress's legislative powers, including its powers to regulate commerce and to levy taxes.

The other case was filed by the State of Florida, joined by 25 other states,<sup>7</sup> against the federal government. The state plaintiffs are challenging the ACA's expansion of mandatory Medicaid eligibility beginning in 2014, to nearly all people under age 65 with household incomes at or below 133% FPL. The state plaintiffs argue that the ACA's Medicaid expansion is an unconstitutional exercise of Congress's Spending Clause power because, they allege, it improperly coerces the states to participate in the

Medicaid program. The state plaintiffs also join in the private plaintiffs’ argument that the individual mandate is unconstitutional.

The federal government agencies involved in both lawsuits are the three main agencies charged with implementing and administering the ACA: the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor. The federal government maintains that both the individual mandate and the Medicaid expansion are constitutional exercises of Congress’s legislative powers. The federal government wants the Court to uphold the validity of these provisions of the ACA to clear up any uncertainty about whether health care reform implementation will take effect in January, 2014.

**2. What have the lower federal appellate courts decided about the constitutionality of the ACA?**

In the cases accepted by the Supreme Court, the 11<sup>th</sup> Circuit Court of Appeals struck down the individual mandate but upheld the Medicaid expansion.<sup>8</sup> Other federal appellate courts to have considered the merits of constitutional arguments about the ACA include the D.C. Circuit Court of Appeals<sup>9</sup> and the 6<sup>th</sup> Circuit Court of Appeals,<sup>10</sup> both of which upheld the individual mandate. The 4<sup>th</sup> Circuit Court of Appeals<sup>11</sup> dismissed two ACA cases concerning the individual mandate, finding that the suits were barred under the Anti-Injunction Act (discussed below). Other cases were dismissed based upon the plaintiffs’ failure to establish standing to sue in the 3<sup>rd</sup>, 8<sup>th</sup>, and 9<sup>th</sup> Circuit Courts of Appeals, and additional ACA cases currently are pending in the 3<sup>rd</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Circuit Courts of Appeals. Table 1 summarizes the federal appellate courts’ decisions to date. Nearly all the pending lower court cases concerning the ACA have been put on hold awaiting the Supreme Court’s decision. Information about the current status of ACA lawsuits across the country is available on the Health Law and Litigation website, maintained by the National Health Law Program and Georgetown University Law Center’s O’Neill Institute for National and Global Health Law, at <http://www.healthlawandlitigation.com/index.html>.

**Table 1: Summary of Circuit Courts of Appeals Decisions in ACA Litigation**

	Plaintiffs’ Standing	Anti-Injunction Act	Individual Mandate	Medicaid Expansion
3 <sup>rd</sup> Circuit	No standing			
4 <sup>th</sup> Circuit		ACA cases barred		
6 <sup>th</sup> Circuit			Upheld	
8 <sup>th</sup> Circuit	No standing			
9 <sup>th</sup> Circuit	No standing			
11 <sup>th</sup> Circuit			Struck down	Upheld
D.C. Circuit			Upheld	

**3. What issues will the Supreme Court consider in its review of the ACA?**

The Supreme Court has agreed to hear four issues. The Court will decide the constitutionality of two of the ACA’s major provisions, the individual mandate and the Medicaid expansion. These two

issues raise fundamental questions about the division of legislative power between the federal government and the states, including the Congress's powers to regulate commerce and to tax and spend. The Court also accepted two additional issues related to the individual mandate. If the Court finds the individual mandate unconstitutional, it will decide whether the mandate is severable, allowing the rest of the ACA to remain in effect or whether all or part of the entire law must be invalidated along with the individual mandate. In addition, the Court will consider whether this is the appropriate time for courts to rule on the ACA's constitutionality or instead whether the Anti-Injunction Act prevents courts from deciding lawsuits about the ACA until after taxpayers actually incur the financial penalty for failure to comply with the individual mandate. A diagram depicting the various legal questions before the Court is available from Kaiser Health News at <http://www.kaiserhealthnews.org/Stories/2011/November/18/supreme-court-health-law-chart-2012.aspx>.

**4. What are the main arguments about the constitutionality of the individual mandate?**

The private and state plaintiffs contend that the individual mandate is not a valid exercise of Congress's legislative powers. The parties' arguments have centered around three constitutional provisions as a basis for the individual mandate: the Commerce Clause, the Necessary and Proper Clause, and the Taxing Power.

*The Commerce Clause*

The main constitutional provision at issue is Congress's ability to regulate interstate commerce. Article I, Section 8 of the U.S. Constitution in pertinent part provides that "Congress shall have Power. . . to regulate Commerce with foreign Nations, and among the several States, and with Indian Tribes." The Supreme Court's existing Commerce Clause cases establish that Congress can regulate any economic activity that Congress rationally concludes is in the stream of or substantially affects interstate commerce. The text of this constitutional provision speaks to Congress's ability to regulate commerce among the states and does not distinguish between economic activity and inactivity.

The plaintiffs argue that a decision to not purchase health insurance constitutes inactivity, which is not connected to interstate commerce, and therefore is not subject to regulation under Congress's commerce power. Instead, the plaintiffs maintain that the individual mandate compels people to enter the stream of commerce, which they argue is an unprecedented use of Congress's commerce power. They maintain that the federal government is one of limited enumerated powers, with all remaining legislative powers residing in the states, which retain the general police power to regulate for the general welfare.

In response, the federal government argues that because everyone will use health care at some point in their lives, and the need for expensive health care services can be unpredictable, Congress can validly require people to buy insurance to limit the costs imposed by the uninsured on the other people in the market. When enacting the ACA, Congress found that people who do not purchase health insurance typically do not pay the full cost of the health care services that they end up consuming, because for example, hospitals may not turn away people in need of emergency care. Instead, these

costs are shifted to health care providers, insurers, and people who have insurance in the form of higher premiums, creating, in the federal government's view, a substantial burden on interstate commerce. The federal government also argues that for the private health insurance market to function effectively, with affordable premiums for everyone, including people with pre-existing conditions, currently healthy people must participate in the market as part of the risk pool. In response to the plaintiffs' argument that upholding the individual mandate will not leave any meaningful limits on Congress's Commerce Clause power, the federal government argues that the appropriate check on Congress's exercise of its legislative powers is the electorate, not the courts.

#### *The Necessary and Proper Clause*

The federal government also asserts that the individual mandate is a valid exercise of Congress's power to enact laws that are "necessary and proper" for executing its enumerated powers, such as the Commerce Clause. Article I, Section 8 of the U.S. Constitution in pertinent part provides that "Congress shall have Power. . . to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof." The plaintiffs maintain that the Necessary and Proper Clause is not an independent source of federal legislative power, and if, as they argue, the mandate is an invalid exercise of the commerce power, it cannot be saved by the Necessary and Proper Clause.

#### *The Taxing Power*

The other constitutional provision at issue regarding Congress's power to enact the individual mandate is the taxing power. The federal government argues that the individual mandate's "practical operation" is as a tax because the financial penalty for failure to comply with the mandate will be administered through the tax code and reasonably relates to the raising of some amount of federal revenue. The plaintiffs argue that the mandate is not a valid exercise of Congress's taxing power because the sanction for failure to comply with the mandate operates as a civil regulatory penalty and not as a tax.

### **5. What are the implications of a Supreme Court decision on the constitutionality of the individual mandate?**

Within the context of the ACA, if the Court upholds the individual mandate, this provision of the law will take effect in 2014. If the Court invalidates the individual mandate, it will then consider whether the mandate is severable from the remainder of the law (discussed below), which could impact whether the ACA's other provisions, particularly those related to expanding access to affordable health insurance coverage, survive and how they are implemented. Within the broader context of Congress's legislative powers, the Court's decision may clarify, reaffirm, or reverse course on existing constitutional doctrine, with potentially significant effects on Congress's power to regulate interstate commerce and the constitutional balance of legislative power between the federal government and the states more generally.

**6. If the Court invalidates the individual mandate, how could the issue of severability affect the ACA?**

If the Court decides that the individual mandate is unconstitutional, it then must decide whether the mandate is “severable” so that the rest of the ACA would survive. If the mandate is found to be unconstitutional and not severable, the entire ACA would be struck down. The Court also could decide to invalidate only some provisions of the law. The Court must determine whether the rest of the law can function independently of the individual mandate provision and whether Congress would have enacted the ACA’s other provisions without the mandate.

In the case before the Supreme Court, the trial court held that the mandate was not severable and invalidated the entire ACA. On appeal, the 11<sup>th</sup> Circuit reversed the trial court’s severability decision and struck down only the individual mandate, allowing the rest of the ACA to survive. The plaintiffs argue that the entire ACA should be struck down if the individual mandate is found to be unconstitutional because, without the mandate, the remainder of the law will not function as Congress intended.

The federal government argues that only two provisions of the ACA should be invalidated if the individual mandate is found to be unconstitutional: the guaranteed-issue provision, which bars insurers from refusing to offer coverage due to a pre-existing condition, and the community-rating provision, which bars insurers from charging higher premiums based on a person’s medical history. The federal government maintains that these two provisions would not effectively achieve Congress’s goal of making affordable coverage widely available in the absence of the individual mandate, because without the mandate, individuals could delay purchasing health insurance, and thus the health insurance market would not function effectively as Congress intended. The federal government argues that the rest of the ACA should survive because its numerous other provisions, some of which already have taken effect, are wholly unrelated to the individual mandate.

Because none of the parties is taking the position that only the individual mandate should be severed, allowing the remainder of the law to survive, as decided by the 11<sup>th</sup> Circuit Court of Appeals, the Supreme Court has appointed outside counsel to argue that position.

**7. What is the Anti-Injunction Act, and how could it affect the case?**

Before reaching the constitutionality of the individual mandate, the Court must decide whether the federal Anti-Injunction Act (AIA) prevents the courts from deciding lawsuits about the ACA at this time. The AIA is a part of the Internal Revenue Code that bars lawsuits that seek to restrain the assessment or collection of a tax. The AIA in pertinent part provides that, subject to certain exceptions, “no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person.”<sup>12</sup> Instead, individuals who want to challenge the imposition of federal taxes in the courts must first pay the tax and then seek to have the tax refunded or raise arguments about the invalidity of the tax as a defense in an IRS enforcement action. The AIA applies only to taxes and not to other sanctions contained in the federal tax code, such as non-tax penalties. The AIA is a very complex law, but essentially, taxes are enacted to raise funds to support the government, and penalties are

imposed as punishment for unlawful acts. Thus, the issue before the Court turns on whether the ACA's monetary sanction for failure to comply with the individual mandate is considered to meet the legal definition of a "tax" or a "penalty" under the AIA.

If the Court decides that the ACA's monetary sanction is a "tax" for purposes of the AIA, the courts do not have jurisdiction to hear challenges to this part of the ACA until after the tax has been assessed, which would be sometime in 2015, after 2014 tax returns are due. If the Court instead decides that the ACA's monetary sanction is a "penalty" under the AIA, then the current case can proceed, and the Court can issue a decision about the constitutionality of the individual mandate now.

The private and state plaintiffs and the federal government all argue that the AIA does not apply to the ACA's financial penalty and therefore the Court presently has legal authority to determine the constitutionality of the individual mandate. Nevertheless, the Court has to consider whether the AIA applies because this question affects whether the Court has jurisdiction to hear the case. Because none of the parties currently argue that the case is barred by the AIA (although the federal government previously took the position that the AIA did apply), the Court has appointed outside counsel to argue that the AIA does bar current lawsuits about this part of the ACA.

#### **8. What are the main arguments about the constitutionality of the Medicaid expansion?**

The Court will decide whether the ACA's Medicaid expansion is a valid exercise of Congress's spending power. Article I, Section 8 of the U.S. Constitution in pertinent part provides that "Congress shall have Power. . . to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States." The state plaintiffs argue that the Medicaid expansion unconstitutionally coerces the states by conditioning their receipt of federal Medicaid funds on their provision of coverage to an additional mandatory eligibility group, adults under age 65 with household incomes up to 133% FPL (\$14,484 per year for an individual in 2011). They allege that federal Medicaid funds are so important to states that the option to participate in the Medicaid program, and thereby comply with the associated federal requirements, has instead become coercive, and Congress should not be allowed to regulate the states in this way through the Spending Clause when it could not do so outside the Spending Clause through one of its enumerated powers.

The federal government argues that Congress may attach conditions to the receipt of federal funds pursuant to its Spending Clause power, and no court has ever invalidated such a condition as coercive. The federal government also argues that Congress has expressly reserved the right to amend the Medicaid Act, that Congress has repeatedly expanded the Medicaid program's mandatory coverage categories over the years, and that the federal government will cover nearly all the costs of the ACA's Medicaid expansion. While a group of states is challenging the Medicaid expansion, other states filed *amicus* (friend of the court) briefs with the trial court in support of the Medicaid expansion.<sup>13</sup>

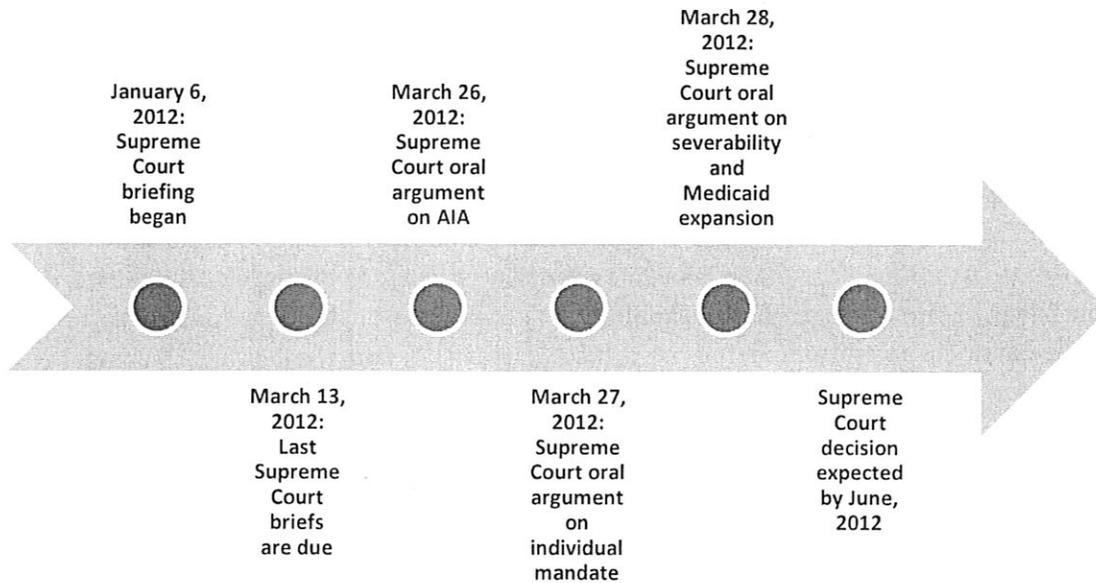
9. What are the implications of a Supreme Court decision on the constitutionality of the Medicaid expansion?

The Court's decision about the constitutionality of the Medicaid expansion could have effects far beyond whether that particular provision of the ACA is implemented, because no court to date has invalidated federal Spending Clause legislation on the basis that it is unduly coercive of states. Any developments in this area of constitutional law could extend to the wide range of Spending Clause legislation, including civil rights statutes that prohibit discrimination on the basis of race, gender and disability and federal laws in a myriad of areas, such as education, transportation, and national security. While the language of the Court's *certiorari* grant on severability is limited to the individual mandate, if the Court did find the Medicaid expansion unconstitutional, it likely would have to determine whether the Medicaid expansion is severable from the rest of the ACA as well. If both the individual mandate and the Medicaid expansion are struck down, the ACA will lack two major provisions to expand access to affordable health insurance. If the individual mandate is upheld and only the Medicaid expansion is invalidated, cost-sharing subsidies through the exchanges would be available only for individuals with incomes at or above 100% FPL, and Medicaid coverage of people with lower incomes would be at state option and at the states' regular federal matching rates, not the enhanced rates provided in the ACA.

**Looking Ahead<sup>14</sup>**

The Supreme Court case is proceeding on a relatively fast timeframe, as all of the parties agree that resolving the constitutionality of the ACA is important so that states can understand what is needed to plan for the implementation of the Medicaid expansion, assistance available through the exchanges, and other aspects of health reform scheduled to take effect in January, 2014. In early January 2012, the parties began filing with the Court their written arguments on each issue, and briefing will end in mid-March 2012. A number of *amicus* briefs, by organizations who are not parties to the case but who can provide additional helpful information to inform the Court's decisions, also are expected to be filed on both sides of the issues. The Court will then hear extensive oral argument on the case over three days, devoting one hour to the Anti-Injunction Act on March 26, 2012, two hours to the individual mandate on March 27, 2012, and an hour and a half to severability and one hour to the Medicaid expansion on March 28, 2012. Although there is no set timeframe within which the Court must act, it is likely to issue a written opinion before the close of the current term in June, 2012. Figure 1 depicts upcoming key dates in the case. As the case progresses at the Supreme Court, all of the filings will be posted at <http://www.supremecourt.gov/docket/PPAACA.aspx>.<sup>15</sup>

Figure 1: Timeline of Key Dates in Supreme Court ACA Case



This policy brief was prepared by MaryBeth Musumeci of the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured. The author thanks Andy Schneider, consultant to the Kaiser Commission on Medicaid and the Uninsured, for his helpful comments.

**Endnotes**

<sup>1</sup> No. 11-398.

<sup>2</sup> No. 11-400.

<sup>3</sup> For more information about the ACA, see [www.healthreform.kff.org](http://www.healthreform.kff.org).

<sup>4</sup> For more information about the Medicaid program’s required and optional elements, see Kaiser Commission on Medicaid and the Uninsured, *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues* (April, 2011), available at <http://www.kff.org/medicaid/upload/8174.pdf>.

<sup>5</sup> Letter from Douglas Elmendorf, Director, Cong. Budget Office to Hon. Nancy Pelosi, Speaker, U.S. House of Reps. (March 20, 2010), available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

<sup>6</sup> Two more individual plaintiffs recently were added to the case after one of the original individual plaintiffs closed her business and filed for bankruptcy, thereby calling into question whether she would be subject to the individual mandate.

<sup>7</sup> The states joining Florida are Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

<sup>8</sup> *State of Florida, et al. v. U.S. Dep’t of Health & Human Servs., et al.*, Nos. 11-11021 & 11-11067 (11<sup>th</sup> Cir., Aug. 12, 2011), available at <http://www.uscourts.gov/uscourts/courts/ca11/201111021.pdf>.

<sup>9</sup> *Susan Seven-Sky, et al. v. Eric H. Holder, Jr., et al.*, No. 11-5047 (D.C. Cir., Nov. 8, 2011), available at [http://www.cadc.uscourts.gov/internet/opinions.nsf/055C0349A6E85D7A8525794200579735/\\$file/11-5047-1340594.pdf](http://www.cadc.uscourts.gov/internet/opinions.nsf/055C0349A6E85D7A8525794200579735/$file/11-5047-1340594.pdf).

<sup>10</sup> *Thomas More Univ. Law Center, et al. v. Obama, et al.*, No. 10-2388 (6<sup>th</sup> Cir. June 29, 2011), available at <http://www.ca6.uscourts.gov/opinions.pdf/11a0168p-06.pdf>.

<sup>11</sup> *Commonwealth of Va., et al. v. Sebelius et al.*, Nos. 11-1057, 11-1058 (4<sup>th</sup> Cir. Sept. 8, 2011), available at <http://pacer.ca4.uscourts.gov/opinion.pdf/111057.P.pdf>; *Liberty Univ., et al. v. Geithner, et al.*, No. 10-2347 (4<sup>th</sup> Cir. Sept. 8, 2011), available at <http://pacer.ca4.uscourts.gov/opinion.pdf/102347.P.pdf>.

<sup>12</sup> 26 U.S.C. § 7421(a).

<sup>13</sup> States that filed *amicus* briefs in support of the Medicaid expansion in the federal district court include Colorado, Iowa, Kentucky, Maryland, Michigan, Pennsylvania, Oregon, Vermont, and Washington. Note that in some states, the governor and the attorney general filed briefs on opposite sides.

<sup>14</sup> See also Drew Altman, Ph.D., President and CEO, Kaiser Family Foundation, *Pulling It Together, 2012: The ACA, and More* (Jan. 4, 2012), available at <http://www.kff.org/pullingittogether/2012.cfm>.

<sup>15</sup> Additional information and resources about the cases are available at the Supreme Court of the United States (SCOTUS) blog's health care page, <http://www.scotusblog.com/category/special-features/health-care/>.

This publication (#8270) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).

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## Washington Health Policy Week in Review States May Opt for Small-Business Model for Essential Benefits, Commissioner Says

*By Jane Norman, CQ HealthBeat Associate Editor*

February 3, 2012 -- The Rhode Island insurance commissioner predicted last week that many states may opt to use existing small-business plans in their states as models for their essential benefits packages under the health care law.

In addition, Christopher Koller said that the approach adopted by the Department of Health and Human Services to allow states to use flexibility in determining their approach will put them on track toward getting exchange packages and benefits up and running by 2014. "As an implementer in the states, what they have done is give me a road map so we can at least put this in place in the next year and a half," he said.

States are expected by Jan. 1, 2013, to demonstrate that they can run their exchanges, and the exchanges are supposed to be up and running by the beginning of 2014. They also must adopt plans for essential health benefits.

Rhode Island, under Gov. Lincoln Chafee, an independent, is one of the states considered to have made the most progress in constructing its exchange. Rhode Island received a \$58.5 million Level Two exchange grant in November from HHS. Koller was also a member of an Institute of Medicine panel that made recommendations last year on how the benefits should be structured.

Koller's remarks came during a discussion on essential health benefits sponsored by the nonpartisan Alliance for Health Reform and The Commonwealth Fund. The Department of Health and Human Services (HHS) in December issued a bulletin outlining how these minimum coverage standards will be defined when individual or small-business plans are sold inside or outside state-run exchanges when the health law is fully in force in 2014.

Instead of laying out one standard package that would be used in all states, HHS said it would give states the leeway to pick a benchmark plan that covers 10 categories of care defined in the health care law (PL 111-148, PL 111-152). States can select among four options—any of the three largest small-group plans by enrollment, any of the three largest state employee health plans, any of the largest federal employee plans or the largest commercial non-Medicaid HMO.

States where lawmakers have added required benefits beyond those packages will have to add them to their benchmark plans.

Many questions are swirling around this essential benefits issue, participants in the discussion acknowledged. And HHS officials have said they will be offering additional guidance and rulemaking at some point. Criticism of the bulletin has centered around the idea that there may be wide variation among states rather than a single national benefit package.

Koller, though, said he thinks the government struck a balance between affordability and a comprehensive package. "I think they threaded that needle very carefully," Koller said. While he said he might wish they had "set the bar higher" and relied more on the recommendations in the Institute of Medicine report, momentum has to be maintained, Koller said.

"I don't pretend to speak for all the states" but there will be a "strong impetus to default to the small-group options because they are the ones commercial regulators know the best," Koller said. Those are plans state regulators have already approved.

There also needs to be clarification on who will make the final decision about which benchmark plan will be used, he noted. "Is it the legislators? Can the executive branch do it?" he asked. "We need to work on that."

Another panelist, Janet Trautwein of the National Association of Health Underwriters, said the vast majority of insured people today are covered by large and small employers. And she said that coverage in both markets is "extremely comprehensive" despite fears by some that the small-business model won't be adequate. Trautwein, who represents insurance brokers, said that a December survey by her group found people with employer-sponsored coverage, for example, receive emergency care and hospital care under every health plan.

Using the benchmark idea may allow states to move more quickly to create their packages. But mandates for coverage do differ from state to state, she said.

One of the most common questions surrounding the benefits packages is affordability, and employers are worried about whether they will be able to continue to offer coverage to their workers, Trautwein said. Workers are worried about whether they can foot the bill for their share. If cost is not taken into account, it will make affordable coverage difficult for both sides, sending workers into the exchanges, she said.