Nos. 11-11021-HH & 11-11067-HH

In the
United States Court of Appeals
for the Eleventh Circuit

STATE OF FLORIDA, by and through Bill McCollum, et al,

Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al,

Defendants-Appellants,

On Appeal from the United States District Court
for the Northern District of Florida
No. 10-cv-91 (Vinson, J.)

BRIEF OF THE STATES OF OREGON, CALIFORNIA, IOWA, DELAWARE, NEW YORK, MARYLAND, CONNECTICUT, HAWAII, AND VERMONT, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF DEFENDANTS-APPELLANTS

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U.S. COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

State of Florida, et al.,

v.

United States Dep't of Health and Human Services, et al.

Nos. 11-11021 & 11-11067

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to 11th Cir. R. 26.1-1, the undersigned counsel certifies that, in addition to the persons, firms, and associations identified in Appellants' opening brief, the following persons, firms, and associations may have an interest in the outcome of this case.

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BRIEF OF THE STATES OF OREGON, CALIFORNIA, IOWA, DELAWARE, NEW YORK, MARYLAND, CONNECTICUT, HAWAII, AND VERMONT, AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF DEFENDANTS-APPELLANTS

INTERESTS OF THE AMICI

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

As part of their responsibility to help provide access to affordable care for their citizens, Amici have engaged in varied, creative, and determined state-by-state efforts to expand and improve health insurance coverage in their states and to contain healthcare costs. Despite some successes, these state-by-state efforts mostly have fallen short due in part to the strongly

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

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

[3] The ACA refers to the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, and the Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111–152.

interstate nature of the healthcare market which limits effective intrastate regulation.

California's dire situation illustrates the problems facing Amici. In 2009, more than 7.2 million Californians—nearly one in four people under the age of 65—lacked insurance for all or part of the year.[4] More than 5.5 million Californians who could not afford private insurance were enrolled in government-sponsored health plans, which will cost the State a projected $42 billion in the next fiscal year.[5] Of those funds, $27.1 billion comes from the General Fund, which faces a $25 billion deficit.

Other states are also grappling with the spiraling cost of medical care and health insurance. For example, despite a variety of legislative efforts to increase access to insurance coverage, 21.8% of Oregonians lack health insurance and The Urban Institute has predicted that without comprehensive

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[4] UCLA Center for Health Policy Research, *Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform* (Feb. 2011) at 2, *available at*: http://www.healthpolicy.ucla.edu/pubs/files/twothirdspb-2-16-2011.pdf (last visited April 1, 2011).

[5] 2011–2012 Governor's Budget Summary at 95–96 (Jan. 10, 2011), *available at*: http://www.ebudget.ca.gov/pdf/BudgetSummary/FullBudget Summary.pdf (last visited April 1, 2011).

healthcare reform, that figure will rise to 27.4% by 2019.[6] In 2009, Oregon spent $2.6 billion on Medicaid and the Children's Health Insurance Program. Without comprehensive healthcare reform, the cost is expected to double to $5.5 billion by 2019.[7]

Maryland's struggle also provides a useful example. Despite the State's expansion of its Medicaid program and the introduction of the Maryland Health Insurance Plan (MHIP), 16.1% of Marylanders still lack health insurance.[8] In the face of an unexpectedly high demand for coverage and the high cost of claims, MHIP was forced, between 2006 to 2010, to increase premiums by about 40%, to institute a $100,000 lifetime cap on pharmacy benefits, and, notwithstanding the Plan's objective to provide insurance for otherwise uninsurable individuals, to begin excluding benefit claims for preexisting conditions during the first six months of an

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[6] Bowen Garrett et al., *The Cost of Failure to Enact Health Reform: Implications for States*, 51 (Robert Wood Johnson Foundation and the Urban Institute Oct. 1, 2009), *available at*: http://www.urban.org/uploadedpdf/411965_failure_to_enact.pdf (last visited April 1, 2011).

[7] *Id.*

[8] *Id.*

individual's enrollment in the Plan. Moreover, in 2009, the State's hospitals provided $999 million in uncompensated care to those without insurance.[9]

The economic situation that states now face is unsustainable. Without comprehensive and coordinated healthcare reform, state-level healthcare costs will rise dramatically over the next 10 years. Even as states are forced to spend more and more to keep up with skyrocketing healthcare costs, the number of individuals without insurance will continue to rise. As a consequence, comprehensive national healthcare reform is urgently needed.

While recognizing the pressing need for national reforms to address the healthcare crisis, Amici also have a keen interest in reforms that will maintain the balance of power between the states and national government. Amici have long been leaders and innovators in the healthcare policy arena, and intend to continue in that role. As states that remain committed to finding innovative ways to improve our citizens' healthcare, Amici have a special interest in reforms that respect the principles of cooperative federalism and that will allow states to maintain a central role in shaping healthcare policy within their borders.

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[9] Maryland Health Services Cost Review Commission, ANNUAL REPORT TO THE GOVERNOR 4 (2010), *available at:* http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/AnnualReports/GovReport10_MD_HSCRC.pdf (last visited Mar. 31, 2011).

The ACA is a comprehensive national solution that embraces the principle of cooperative federalism and that will help Amici fulfill their duty to protect and promote the health and welfare of their citizens. It strikes an appropriate, and constitutional, balance between national requirements that will expand access to affordable healthcare while providing states flexibility to design programs that achieve that goal. Amici urge this Court to reverse the decision of the district court and uphold this important law.

STATEMENT OF THE ISSUES

1. **Whether the district court erred in holding that Congress exceeded the scope of its authority under the Commerce Clause when it enacted the ACA's minimum coverage provision.**

2. **Whether the district court erred in holding that Congress exceeded the scope of its authority under the Necessary and Proper Clause when it enacted the ACA's minimum coverage provision.**

3. **Whether the district court erred in holding that the minimum coverage provision is not severable from the rest of the ACA.**

SUMMARY OF ARGUMENT

The minimum coverage provision fits easily within Congress's Commerce Clause authority as articulated by the Supreme Court. In reaching a contrary conclusion, the district court erroneously reasoned that the provision was unlawful because it regulates "inactivity." But the

Supreme Court has never relied on a distinction between "activity" and "inactivity" in examining the scope of Congress's Commerce Clause authority, much less suggested that the distinction is in any way relevant for purposes of the Commerce Clause. Nor is there a sound reason for injecting that dubious dichotomy into the analysis here. Whether choosing to forgo health insurance should be characterized as an "activity" or "inactivity" is a fruitless semantic inquiry with no correct answer and thus no analytical content. Attempting to draw a line between laws that regulate "activity" and laws that regulate "inactivity" does not provide a workable framework for Commerce Clause analysis.

Under the established framework articulated by the Supreme Court, the minimum coverage provision is a justifiable exercise of Congress's Commerce Clause authority for either of two reasons. First, in the aggregate, individual decisions to maintain a minimum level of insurance coverage substantially affect interstate commerce by pooling risk, lowering healthcare costs, and reducing uncompensated care for everyone. Conversely, in the aggregate, individual decisions to forgo coverage raise the cost of healthcare and shift the cost of providing uncompensated care to the states and those who pay for coverage. Second, and in any case, the

minimum coverage provision is constitutional because it is essential to Congress's regulation of the national healthcare market.

The minimum coverage provision is also justified by the Necessary and Proper Clause. Not only is the minimum coverage provision necessary to carry out Congress's goals of lowering the costs of medical care and expanding insurance coverage, it is a proper exercise of federal authority that does not alter the essential attributes of state sovereignty. The ACA continues a longstanding and necessary partnership between the states and the federal government in the healthcare policy arena.

After erroneously concluding that the minimum coverage provision is unconstitutional, the district court compounded the error by concluding that the provision is not severable from the remainder of the ACA and striking down the entire law. The ACA contains hundreds of healthcare reform provisions, the overwhelming majority of which are completely independent of the minimum coverage provision. As the States' experience implementing the ACA already demonstrates, those provisions are entirely capable of being applied independent of the minimum coverage provision, which has not yet gone into effect. The district court's decision to nullify every provision in the ACA is without justification.

STATUTORY BACKGROUND

The ACA is a comprehensive reform law that supplies hundreds of tools for the states, in partnership with the federal government, to expand access to affordable and reliable healthcare. The ACA relies in large part on an expansion of the current market for health insurance, building upon existing state and federal partnerships to improve access to healthcare. Collectively, these reforms will result in broader healthcare coverage, reductions in state spending for uncompensated care, and improved quality of care.

The law anticipates that the majority of the population will be covered through their employer or through expanded access to government-run plans such as Medicaid. While the ACA requires businesses with more than fifty employees to begin providing health insurance in 2014, ACA § 1513, small businesses have already started taking advantage of the ACA's significant tax breaks, including some of the thousands of businesses eligible in the Eleventh Circuit. ACA § 1421.[10] The ACA also expands access to Medicaid to individuals who earn less than 133 percent of the federal poverty level, and funds 100 percent of the cost until 2017. ACA § 2001(a).

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[10] http://www.irs.gov/pub/newsroom/count_per_state_for_special_post_card_notice.pdf (last visited April 8, 2011).

For those individuals who do not obtain health insurance from their employer or from government-run plans, the ACA makes affordable coverage more readily available. It eliminates annual and lifetime caps on health insurance benefits so that individuals can maintain coverage during a catastrophic illness. ACA § 10101(a). The ACA also authorizes states to create health insurance exchanges that will allow individuals and small businesses to pool together so that they have the purchasing power of larger corporations. ACA § 1311.

The ACA also makes it easier to obtain health insurance by prohibiting insurance companies from refusing to cover individuals with preexisting conditions starting in 2014. ACA § 1201. A significant number of people who are uninsured are currently unable to purchase insurance or are required to pay much higher premiums due to a preexisting condition, which can include common illnesses such as heart disease, cancer, asthma, or even pregnancy.[11] The ACA thus dramatically increases the availability of insurance for previously uninsurable individuals.

The ACA reforms will allow states to substantially expand and improve healthcare coverage. Oregon, for example, estimates that the ACA

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

will allow the State to reduce the number of uninsured to just 5% by 2019—a vast improvement over the 27.4% the State forecasts will be uninsured by that time without the reforms.[12]

The only provision of the ACA that the district court concluded was constitutionally infirm is the minimum coverage provision, which requires most residents of the United States, starting in 2014, to obtain health insurance or pay a tax. ACA § 1501. Residents whose income falls below a specified level or who can demonstrate that purchasing insurance would pose a hardship are exempt from the penalty for failing to obtain health insurance. ACA § 1501(e). In effect, the minimum coverage provision is targeted at those who, while they can afford it, choose not to purchase insurance and choose instead to "self insure," relying on luck, their own financial reserves, and the healthcare social safety net of emergency rooms and public insurance programs to catch them when they fall ill.

ARGUMENT

I. Congress has the authority under the Commerce Clause to enact the ACA's minimum coverage provision.

The Supreme Court has recognized Congress's power under the Commerce Clause includes the authority to regulate economic activities that,

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[12] Bowen Garrett et al., *supra* note 5.

in the aggregate, have a "substantial effect on interstate commerce." *Gonzalez v. Raich*, 545 U.S. 1, 17 (2005). In addition, Congress may regulate local, noneconomic activity provided such regulation is "an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *United States v. Lopez*, 514 U.S. 549, 561 (1995). As explained below, the minimum coverage provision is a justifiable exercise of Congress's Commerce Clause power under both formulations.

A. In articulating Congress's regulatory power, the Supreme Court has never distinguished between "activity" and "inactivity," nor does that distinction provide a workable framework for analysis.

In striking down the ACA, the district court concluded that the minimum coverage provision was an unlawful and unprecedented attempt by Congress to regulate "inactivity." According to the district court, "it would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause." (Dist. Ct. Op. at 42.)[13]

[13] The district court made much of the argument that "[n]ever before has Congress required that everyone buy a product from a private company . . ." and the "assumed absence of such power." (Dist. Ct. Op. at 38-39). That assumption is contradicted by The Militia Act of 1792, which the 2nd Congress enacted shortly after the Bill of Rights was ratified. That law required "every free able-bodied white male citizen" between 18 and 45 to "provide himself with a good musket or flintlock, a sufficient bayonet and belt, two spare flints, and a knapsack, a pouch, with a box therein, to contain

The distinction between "activity" and "inactivity," however, has no basis in Supreme Court jurisprudence and is, in fact, illusory.

None of the Supreme Court's Commerce Clause cases have addressed the question of whether the regulated conduct was properly characterized as "activity" or "inactivity," much less suggested that such a distinction is in any way relevant or useful to the analysis. The Supreme Court's Commerce Clause decisions, including *Wickard v. Filburn*, 317 U.S. 111, 128 (1942), *Lopez*, *United States v. Morrison*, 529 U.S. 598, 610 (2000), and *Raich*, have referred to Congress's power to regulate "economic activity." The district court concluded from the Supreme Court's use of that term that Congress can only regulate activity, not inactivity. But that reasoning is fallacious, and it elevates descriptive statements into a holding. The Supreme Court's discussions of "economic activity" have been focused on whether the conduct at issue was in fact *economic*, not on whether it was properly characterized as "activity."

Distinguishing "activity" from "inactivity" is inherently problematic. In fact, many regulations can be characterized as regulating both "activity"

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not less than twenty-four cartridges" at his own expense. The Militia Act dramatically illustrates that the "original understanding" afforded the federal government power to compel individuals to make a substantial purchase when appropriate for the common good.

and "inactivity," illustrating the false distinction between the two. For instance, the failure to comply with draft registration requirements can be viewed as inaction or as an affirmative act of disobedience. *See* 50 U.S.C. App. 451 *et seq*. So too can the failure to appear for federal jury duty as required by 28 U.S.C. § 1854(b) be seen either as an affirmative action of evading jury service or as no action at all. Such examples belie the district court's contention that regulation of "inactivity" is "unprecedented." To the contrary, it is commonplace.

Remarking on the inherent difficulty in distinguishing "activity" from "inactivity," Justice Scalia has observed that "[e]ven as a legislative matter…the intelligent line does not fall between action and inaction." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 296 (1990) (Scalia, J., concurring). The same could be said here. While it may be semantically possible to characterize the decision not to purchase health insurance as "inactivity," as the district court did, it is at the very least equally reasonable to characterize that decision as "activity." Indeed, at least three other federal courts considering the issue have already concluded that such a decision *is* properly characterized as economic "activity." As Judge Kessler of the United States District Court for the District of

Columbia recently wrote in granting the government's motion to dismiss a claim similar to that before this Court:

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

Mead v. Holder, 2011 WL 61139, *18 (D.D.C. Feb. 22, 2011). *See also, Liberty Univ., Inc. v. Geithner*, 2010 WL 4860299, at *3-8 (W.D. Va. Nov. 30, 2010); *Thomas More Law Ctr. v. Obama*, 720 F.Supp.2d 882, 887-90 (E.D. Mich. 2010).

The inability of the lower courts to agree on whether the minimum coverage provision regulates "activity" or "inactivity" reflects the inherent problem with that line of inquiry. Asking whether an individual's decision to forgo health insurance is "action" or "inaction" is a fruitless query, the answer to which depends entirely on how one frames the question. For that reason, attempting to draw a line between laws that regulate "activity" and laws that regulate "inactivity" does not provide a workable framework for Commerce Clause analysis. The proper question is not whether the decision to refuse to purchase health insurance is best characterized as "action" or "inaction," but rather whether such decisions, in the aggregate, substantially

affect interstate commerce. If they do, Supreme Court precedent recognizes Congress's authority to regulate them. *Lopez*, 514 U.S. at 558–59.

B. The minimum coverage provision is constitutional because Congress had a rational basis for concluding that choosing to forgo health insurance substantially affects interstate commerce.

In *U.S. v. Maxwell*, 446 F.3d 1210 (11th Cir. 2006), this Court recognized that "*Raich* grants Congress substantial leeway to regulate purely intrastate activity (whether economic or not) that it deems to have the capability, in the aggregate, of frustrating the broader regulation of interstate economic activity." *Id.* at 1215. In determining whether a regulated activity substantially affects interstate commerce within the meaning of the Commerce Clause, the Court "need not determine whether . . . [the regulated] activities, taken in the aggregate, substantially affect interstate commerce in fact, *but only whether a 'rational basis' exists for so concluding*. *Raich*, 545 U.S. at 22 (emphasis added).

Here Congress specifically found that the minimum coverage provision regulates activity that is "commercial and economic in nature" and that it "substantially affects interstate commerce." ACA § 1501(a)(1). Moreover, Congress certainly had a rational basis for reaching that conclusion.

An individual's decision to purchase or not purchase health insurance is a decision that, when taken together with the decisions of all individuals similarly situated, substantially affects the market for health insurance and the market for healthcare. In concluding otherwise, the district court mistakenly reasoned that "the mere status of being without health insurance, in and of itself, has absolutely no impact whatsoever on interstate commerce." (Dist. Ct. Op. at 50). Such reasoning fails to grasp the complex reality of the health insurance and healthcare markets, where the aggregated purchasing decisions of individuals who choose not to maintain health insurance have a direct and powerful impact on those markets.

Insurance is a system of shared risk. But in a system where purchasing insurance is purely voluntary, people with higher than average health risks will disproportionately enroll in insurance plans, as an individual is more likely to purchase insurance when he or she expects to require healthcare services. Conversely, those with lower than average risks, especially young Americans, are less likely to purchase insurance.[14] This phenomenon is commonly referred to as "adverse selection."

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[14] In California, for instance, 18 to 34 year-olds represent 43 percent of the state's uninsured. California HealthCare Foundation, *California's Uninsured* at 18 (Dec. 2010), *available at* http://www.chcf.org/publications/2010/12/californias-uninsured (last visited April 1, 2011).

Adverse selection raises the cost of insurance premiums in two ways. First, it raises the overall cost because adverse selection tends to create insurance pools with higher than average risks and premiums reflect the average cost of providing care for the members of the pool. Second, because insurers fear the potentially substantial costs associated with the disproportionate enrollment of people with non-obvious high health risks, they will often add an extra fee to their premiums, particularly in the small group and individual markets. The minimum coverage provision addresses both of these factors, first by driving low-risk people into the risk pool, thus driving down average insurance costs, and second by lessening the probability that a given individual is purchasing insurance solely because he or she knows something the insurer does not know about his or her health status, thereby reducing insurer hedging and the fees associated with adverse selection.

In addition to reducing the cost of health insurance by addressing the problem of adverse selection, the minimum coverage provision also addresses the problem of providing uncompensated care to the uninsured. When individuals choose not to purchase health insurance, they are still participants in the interstate healthcare marketplace: when they get sick, they seek medical attention. The cost of providing this uncompensated care to

the uninsured is staggering: over $40 billion annually, as Congress found in enacting the ACA. ACA § 1501(a)(2)(F), 1016(a). Only one-third of the cost of that care is covered by the uninsured themselves. The remaining two-thirds of the cost are passed on to other public and private actors in the interstate healthcare and health insurance system, and ultimately are passed on to those with health insurance through higher premiums. In California, for instance, in 2006, the average family with health insurance paid an additional $1,186 in premiums to cover the cost of uncompensated care for the uninsured.[15]

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

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[15] Peter Harbage and Len M. Nichols, Ph.D., *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System* (New America Foundation, Dec. 2006).

individuals to the patient population as a whole. Requiring individuals to possess health insurance ends this cost-shifting, lowering the costs of healthcare for everyone and reducing the costs to the States of providing such care.

Massachusetts' experience with healthcare reform demonstrates that a minimum coverage requirement, when combined with a comprehensive reform program, can spread risk, control costs and reduce the financial burdens otherwise borne by health plans and state and federal government programs. As Massachusetts has explained in its amicus brief, it has implemented reforms that require all non-exempt individuals to purchase some form of health insurance coverage. Those reforms have dramatically reduced the number of uninsured, giving Massachusetts the lowest rate of uninsured residents in the nation.[16] As a result, the state experienced a sharp decline in the amount of state spending on healthcare for the uninsured and under-insured.

In summary, Congress had a rational basis for concluding that, in the aggregate, economic decisions regarding how to pay for healthcare

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[16] *See* Mass. Taxpayers Found., *Massachusetts Health Reform: The Myth of Uncontrolled Costs* at 2 (May 2009), *available at* http://www.masstaxpayers.org/sites/masstaxpayers.org/files/health%care-nt.pdf (last visited April 1, 2011).

services—including, in particular, decisions to forgo coverage and to pay later or, if need be, to depend on free care—have a substantial effect on the interstate healthcare and health insurance markets. The Commerce Clause empowers Congress to regulate these direct and aggregate market effects. *See Raich*, 545 U.S. at 16–17; *Wickard*, 317 U.S. at 127–28.

C. The minimum coverage provision is constitutional because it is an essential part of a comprehensive regulatory scheme.

The minimum coverage provision is also constitutional because it is "an essential part of a larger regulation" of the health care industry. Among the purposes of the ACA is the creation of a comprehensive regulatory scheme that will rein in the cost of healthcare coverage, reduce the number of people who lack coverage, and prevent insurance providers from denying coverage to people with preexisting conditions. The minimum coverage provision is an essential part of that scheme. Indeed, Congress expressly found that the minimum coverage provision was "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." ACA § 1501(a)(1). Congress's judgment in that regard—which is entitled to "a strong presumption of validity," *Raich,* 545 U.S. at 28—is plainly justified.

It is beyond dispute that Congress has the power under the Commerce Clause to regulate the provision of health insurance, as it has done for decades. *See United States v. South-Eastern Underwriters*, 322 U.S. 533 (1944); *see also* Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 *et seq.*); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. § 1161 *et seq.*); Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d *et seq.*). Congress found that spending for health insurance was over $850 billion in 2009. ACA. § 1501(a)(2)(B). Nor can it be doubted that Congress has the constitutional authority to regulate the healthcare industry. Seventeen percent of the United States economy is devoted to healthcare. ACA § 1501(a)(2)(B). As Congress recognized, medical supplies, drugs, and equipment used in the provision of healthcare routinely cross state lines. *Id.* And of course, the federal government has for decades been deeply involved in healthcare regulation, including programs such as Medicare, Medicaid, and the Children's Health Insurance Program.

The minimum coverage provision is an important part of Congress's effort to create a regulatory scheme that will allow for affordable, accessible, and robust insurance markets on which all Americans can rely. For example, the ACA prohibits insurers from denying coverage to those with

preexisting conditions. ACA § 2704. But successful implementation of that provision will require incorporating healthy people into the risk pool. The reality is that "[i]nsurance pools cannot be stable over time, nor can insurers remain financially viable, if people enroll only when their costs are expected to be high. . .[a]nd research leaves no doubt that without an individual mandate, many people will remain uninsured" until they get sick.[17] By requiring everyone to pay into the risk pool, the ACA will dramatically reduce adverse selection and make it practical to insist upon coverage for individuals with pre-existing conditions. If pre-existing condition exclusions are eliminated with no requirement that one purchase insurance, people would have an incentive to forgo coverage until they get sick and as a consequence the high-risk pool would collapse from inadequate funding.[18]

The minimum coverage provision is also an essential component of Congress's plan to address the skyrocketing costs of uncompensated care. By requiring individuals to maintain a minimum level of health insurance,

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[17] Linda J. Blumberg & John Holahan, *The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage*, 361 New Eng. J. Med. 6, 6–7 (2009).

[18] *See* Michael C. Dorf, *The Constitutionality of Health Insurance Reform, Part II: Congressional Power* (Nov. 2, 2009), *available at* http://writ.news.findlaw.com/dorf/20091102.html (last visited Jan. 11, 2011).

these costs will be reduced, lowering the burden on states and individuals who are forced to subsidize the care of the uninsured while at the same time alleviating the problem of uninsured individuals using scarce emergency room resources.

As this Court noted in *Maxwell*, "what distinguished *Raich* from *Morrison* and *Lopez* , . . .was the comprehensiveness of the economic component of the regulation." 446 F.3d at 1214. Similarly, because the minimum coverage provision is an integral part of the ACA's "comprehensive framework for regulating" healthcare, the absence of which would severely undercut Congress's regulatory scheme, it is therefore constitutional. *Raich*, 545 U.S. at 3.

II. Congress Also Has the Authority Under the Necessary and Proper Clause to Enact the ACA's Minimum Coverage Provision.

A. The minimum coverage provision is a necessary means to a legitimate end.

Congress's authority under the Commerce Clause is augmented by the Necessary and Proper Clause, which allows Congress to "make all laws which shall be necessary and proper for carrying into execution" the powers enumerated in the Constitution. U.S. Const., art. I, § 8. As Justice Scalia, who was in the majority in *Lopez* and *Morrison*, has explained, the Necessary and Proper Clause authorizes Congress to "regulate even those

intrastate activities that do not substantially affect interstate commerce" as well as "noneconomic local activity" where necessary to make a regulation of interstate commerce effective. *Raich*, 545 U.S. at 35, 37 (Scalia, J., concurring). The minimum coverage provision is necessary to lower the cost of health insurance and to effectuate the ban on denials of coverage based on preexisting conditions. It is therefore within Congress's power to enact.

In rejecting application of the Necessary and Proper Clause, the district court repeatedly emphasized that the Clause is "not an independent source of power" and reasoned that the Clause "cannot be utilized to 'pass laws for the accomplishment of objects' that are not within the Congress's enumerated powers." (Dist. Ct. Op. at 62). While those statements of the law are certainly true, they are also irrelevant here because the minimum coverage provision does not accomplish an objective "outside Congress's enumerated powers." Rather, it is a legitimate and necessary *means* to accomplish an objective—regulation of the nation's $2.5 trillion national healthcare market—that is squarely within the scope of Congress's Commerce Clause power.

Under the Necessary and Proper Clause, Congress's authority includes all means which are appropriate and are properly adapted to legitimate ends.

McCulloch v. Maryland, 4 Wheat. 316, 421 (1819). Thus, the correct inquiry is whether "the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *United States v. Comstock*, 130 S. Ct. 1949, 1957 (2010). In making this determination, courts must give Congress "large discretion as to the means that may be employed in executing a given power." *Champion v. Ames*, 188 U.S. 321, 355 (1903).

In this case, Congress's goal is clearly legitimate: to reduce the expense of healthcare, which consumes over a trillion dollars of the nation's economy, and expand access to health insurance as the federal government has been doing since the passage of the Social Security Act in 1965. So too are the means reasonably adapted. As explained above, the minimum coverage provision ameliorates the problem of adverse selection by expanding the insurance pool which will also result in reduced insurance premiums and lower costs of healthcare. Accordingly, the minimum coverage provision is reasonably adapted, indeed necessary, for several portions of the ACA to function properly.

B. The minimum coverage provision is also a "proper" exercise of congressional authority that does not encroach on state sovereignty.

In addition to being necessary, the minimum coverage provision is also proper. In holding to the contrary, the district court concluded that the minimum coverage provision was inconsistent with the principles of federalism and that allowing such a provision would "effectively remove all limits on federal power." (Dist. Ct. Op. at 62). Amici obviously share the district court's concern with preserving state sovereignty and adhering to the principles of federalism, but we cannot agree that those principles are violated here. In fact, the ACA continues a longstanding and necessary partnership in the healthcare policy arena. The district court's conclusion that the ACA removes all limits on federal power dramatically overstates the authority being claimed by the federal government, and dramatically understates the extent to which the federal government already regulates a significant portion of the health insurance market.

In *Comstock*, the Supreme Court explained that the "powers 'delegated to the United States by the Constitution' include those specifically enumerated powers listed in Article I along with the implementation authority granted by the Necessary and Proper Clause. *Comstock*, 130 S. Ct. at 1962. In his concurrence, Justice Kennedy described one consideration in determining the extent of Congress's power: "whether essential attributes of state sovereignty are compromised by the assertion of federal power under

the Necessary and Proper Clause" *Id.* at 1967–68. In the present case, neither the minimum coverage provision, nor indeed the ACA as a whole, may be said to "compromise" state sovereignty.

The regulation of healthcare and health insurance is not, and never has been, principally a matter for the states. Healthcare is extremely costly and states' ability to raise revenue is far more limited than the federal government's. Virtually all states are unable to run budget deficits,[19] and thus their budgets are often highly variable from year to year, making stable funding for healthcare programs elusive. The healthcare payment and delivery systems are shaped in large part by federal revenue streams, tax policy, and federal statutes, constraining states' ability to engage in truly systematic reform on a state-by-state basis. States also lack the economies of scale that can be achieved on the national level. Furthermore, state-by-state regulation is constrained by the knowledge that businesses and health insurance companies are free to flee to more hospitable states should one state implement stronger protections than its neighbor states.

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[19] The only exception is Vermont. National Conference of State Legislatures, *State Balanced Budget Provisions*, *available at* http://www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf (last visited March 28, 2011).

For all of these reasons, the states and the federal government have been working together to implement healthcare policy for at least the last half-century. The federal government, for example, has provided funding to the states to enable medical insurance and care for the poor under Medicaid, and for low-income children under CHIP. Millions more Americans are covered through federal insurance programs, the military, and the Veterans Administration. The federal government has designed, funded, and administered the Medicare program, which provides health insurance for 96% of the nation's elderly citizens. COBRA , HIPPA, and ERISA set numerous federal requirements for health insurance. The federal government has long been enmeshed in the healthcare and health insurance arenas, frequently working in partnership with the states. For all of the controversy surrounding the ACA, it is not fundamentally different from other cooperative federal-state programs that have been in existence for decades.

The ACA continues the tradition of cooperation between the states and the federal government in a way that respects our system of dual sovereignty and that will allow states to continue to innovate. Among dozens of provisions allowing states flexibility, the law will continue to allow states to take advantage of Medicaid waiver programs and federal funds to expand

access to health insurance and test different approaches to providing care. ACA § 1332. In addition, the ACA provides interested states federal funding and broad latitude to establish exchanges that best meet the needs of their respective citizens, subject to minimum federal standards. ACA § 1311. Similarly, the ACA allows states great latitude in establishing basic health programs for low-income individuals not eligible for Medicaid.

Because of the ACA's inherent flexibility, states may choose to enact further reforms to improve upon the federal reforms contained in the ACA. Indeed, the ACA specifically gives states authority to pass additional regulations pertaining to insurance companies. Pursuant to the authority to oversee any increases in the premiums set by insurance companies, California recently passed a law requiring all premium filings to be reviewed and certified by an independent actuary to ensure premium costs are accurately calculated. Cal. Stats. 2010, Ch. 661. These consumer protections exceed what federal law requires under the ACA. Finally, nothing in the ACA usurps the states' traditional role in regulating the standards for medical care.

When the Social Security Act was enacted in 1935 it, like the ACA, was challenged as an incursion on states' prerogatives. The Supreme Court's rejection of that argument is squarely on point and bears repeating:

> The problem is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. Congress, at least, had a basis for that belief. States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged. . . . Apart from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors. . . . A system of old age pensions has special dangers of its own, if put in force in one state and rejected in another. The existence of such a system is a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose. Only a power that is national can serve the interests of all.

Helvering v. Davis, 301 U.S. 619, 644 (1937). Precisely the same thing could be said of the healthcare crisis currently gripping the states and the nation.

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

III. The Minimum Coverage Provision is Severable from the Remainder of the Affordable Care Act.

For all the reasons explained above, the minimum coverage provision is constitutional. Should this Court conclude that Congress lacked authority to enact the minimum coverage requirement, however, it should sever that provision, and the provisions making reference to it, from the ACA. In deciding to strike down the entire law, the district court made no attempt to determine which of the hundreds of provisions in the ACA were dependent on the minimum coverage provision and which could stand alone. Instead the court essentially threw up its hands, declaring that there are "too many moving parts in the Act" to "try and dissect out the proper from the improper." (Dist. Ct. Op. at 73-74). The district court's decision to strike down the entire Act without even considering the relationship between the minimum coverage provision and the hundreds of other provisions in the law is flatly contrary to the established standard for determining severability.

To determine whether an unconstitutional provision is severable, the Supreme Court applies a "well established" test. "Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a matter of law.'" *Buckley v. Valeo*, 424 U.S. 1, 108 (1976) (internal quotations and citation omitted); *see Free Enterprise Fund v. Public Co. Accounting Oversight Board*, 130 S. Ct. 3138, 3162

(2010). In making this determination, the Court must determine whether the remainder of the act is capable of functioning independently. *Alaska Airlines v. Brock*, 480 U.S. 678, 684 (1987).

There are approximately 450 healthcare reform provisions contained in the ACA, the overwhelming majority of which can be implemented in the absence of the minimum coverage provision. Indeed, Amici have already begun implementing many of these provisions. For instance, in addition to expanding health coverage, the ACA also makes reforms to health insurance plans to ensure that individuals do not lose their coverage. California has enacted legislation implementing the ACA's ban on denying coverage of children based on preexisting conditions, as well as a requirement that insurance plans cover dependent children who are 25 or under. 2010 Cal. Stat., Ch. 656 and 660. California has also passed legislation that prohibits a person's health insurance policyholder from canceling insurance once the enrollee is covered unless there is a demonstration of fraud or intentional misrepresentation of material fact. 2010 Cal. Stat., Ch. 658.

The ACA also contains numerous provisions aimed at improving the quality of healthcare that are independent of the minimum coverage provision. For instance, Title V of the ACA provides new incentives to expand the number of primary care providers through scholarships and loan

repayment programs. Title IV of the ACA requires insurance companies to offer certain preventive services, and authorizes $15 billion for a new Prevention and Public Health Fund, which will support initiatives from smoking cessation to fighting obesity. ACA § 4002. The ACA also includes $4 billion in funding for two programs—one of which, the Money Follows Person (MFP) program, was enacted during George W. Bush's presidency, and was re-authorized by the ACA—that are aimed at moving Medicaid beneficiaries out of institutions and into their own homes or other community settings. ACA § 2403. Recently, the Department of Health and Human Services announced the first round of grants for the MFP program totaling $621 million. Since this program was in effect before the ACA was enacted, it can clearly exist independent of the minimum coverage provision.

The ACA also contains important consumer protections that will assist Amici in their duty to protect individuals from abusive insurance practices. In addition to barring the practice of rescinding coverage, ACA § 2717, the ACA allows consumers to appeal coverage determinations, and establishes an external review process to examine those decisions. ACA § 2719.

Each of the provisions described above is completely independent of the minimum coverage provision, as are hundreds of other provisions in the ACA. These provisions would remain "fully operative" even if the

minimum coverage provision were to be excised. Accordingly, should this Court invalidate the minimum coverage provision, it should sever that provision from the law but leave the vast majority of the ACA intact.

CONCLUSION

The decision of the district court should be reversed.

DATED this 8th day of April, 2011.

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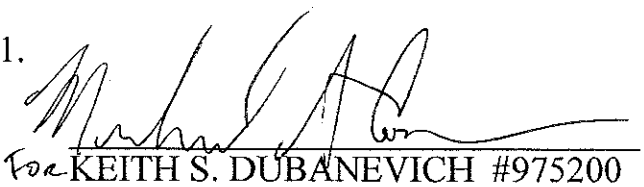
CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation set forth in FRAP 32(a)(7)(B). This brief contains 6985 words.

DATED this 8th day of April, 2011.



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I hereby certify that on April 8, 2011, I directed the Brief of the States of Oregon, California, Iowa, Delaware, New York, Maryland, Connecticut, Hawaii, and Vermont, and the District of Columbia as Amici Curiae in Support of Defendants-Appellants to be filed with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit, 56 Forsyth St. N.W., Atlanta, Georgia, 30303.

I further certify that on April 8, 2011, by agreement with the parties, I served the Brief of the States of Oregon, California, Iowa, Delaware, New York, Maryland, Connecticut, Hawaii, and Vermont, and the District of Columbia as Amici Curiae in Support of Defendants-Appellants by e-mail to the following counsel:

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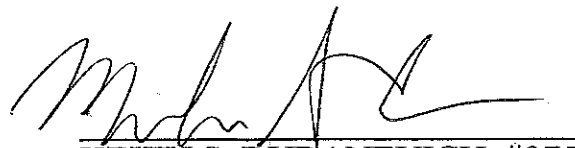

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