No. 11-398

IN THE SUPREME COURT OF THE UNITED STATES

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

v.

STATE OF FLORIDA, ET AL.

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

BRIEF FOR AMICUS CURIAE CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM IN SUPPORT OF PETITIONER, DEPARTMENT OF HEALTH AND HUMAN SERVICES

(MINIMUM COVERAGE PROVISION)

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QUESTIONS PRESENTED

The minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, non-exempted federal income taxpayers who fail to maintain a minimum level of health insurance for themselves or their dependents will owe a penalty, calculated in part on the basis of the taxpayer's household income and reported on the taxpayer's federal income tax return, for each month in which coverage is not maintained in the taxable year. 26 U.S.C.A. 5000A.

The question presented is whether the minimum coverage provision (individual mandate) is a valid exercise of Congress' powers under Article I of the Constitution.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a273a) is reported at 648 F.3d 1235. The district court's opinion on petitioners' motion to dismiss (Pet. App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on cross-motions for summary judgment (Pet. App. 274a-368a) is reported at 780 F. Supp. 2d 1256.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The petition for a writ of certiorari was filed on September 28, 2011, and was granted on November 14, 2011. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT OF INTEREST[1]

Amicus, the California Public Employees' Retirement System (CalPERS) provides health benefits to 1.3 million state, public agency, and school employees and annuitants and their families under the Public Employees' Hospital and Medical Care Act (PEMHCA). The purpose of PEMHCA is to:

> promote increased economy and efficiency in state service, enable the state to attract and retain qualified employees by providing health benefit plans similar to those commonly provided in private industry, and to recognize and protect the state's investment in each permanent employee by promoting and preserving good health among state employees.

Cal. Govt. Code § 22751 (LexisNexis 2011). CalPERS is the largest purchaser of health benefits in California. After the federal government, CalPERS is the second largest purchaser of health benefits in the nation. In 2011, CalPERS spent a total of $6.67 billion in premiums to provide health benefits to its members. *CalPERS Facts at a Glance*, (December 2011) http://www.calpers.ca.gov/eip-docs/about/facts/health.pdf. CalPERS contracts with health insurers, including Kaiser Permanente, Blue

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[1] This Amicus Brief was authored in whole by CalPERS in-house counsel employed by CalPERS and the State of California. No monetary contributions were made in support of its creation or submission.

Shield of California, Anthem Blue Cross, and CVS Caremark, to provide members and their families with access to a variety of health service plan options. In negotiating health plan agreements, CalPERS acts as the agent or representative of its members. *Madden v. Kaiser Found. Hosps.*, 17 Cal.3d 699, 705 (1976.) CalPERS currently offers three health maintenance organization (HMO) plans, three self-funded preferred provider organization (PPO) plans, and three plans for association members.

Since the enactment of the Patient Protection and Affordable Care Act (ACA or Act) CalPERS has committed to implementing the provisions of the Act, including the adoption of regulations necessary for compliance with the ACA, and the negotiation of contractual amendments with CalPERS health plans and third party administrators to bring contracts into compliance with ACA provisions. As a result of the enactment of the ACA, CalPERS has also received federal funding to assist with the cost of early retiree insurance, enrolled thousands of additional family members, and eliminated lifetime benefit caps for certain benefits.

CalPERS submits this Amicus Curiae brief in support of the ACA and the Solicitor General based on the integral role CalPERS plays in setting health policy and purchasing health benefits for 1.3 million members. CalPERS asks this Court to uphold the ACA in its entirety, and in particular to find the "minimum essential coverage" or "individual mandate" provision at 26 U.S.C. § 5000A to be a constitutional exercise of the powers of Congress under the Commerce Clause.

SUMMARY OF ARGUMENT

The cost of providing health care in this country continues to rise. Attempts to control these costs on a local or state basis have fallen short. Each year, the State of California and local governments are forced to spend an increasing percentage of scarce public resources to provide these benefits. Rising costs increase premiums borne by employers and their employees who participate in the CalPERS health plans. The notion that runaway health care costs are a local phenomenon is simply untrue – CalPERS and countless similar organizations are unable to make systemic changes in the health care market to control these costs.

Through the ACA, Congress addressed the health care crisis on numerous fronts by developing a comprehensive framework designed to reduce the cost of health care and increase individual access to the health care system. Insurance reform, health care delivery, and the creation of the Health Benefit Exchange system are being applied to make health care more affordable for and accessible by the uninsured and underinsured. Annette Gardner, Ph.D., *Addressing California's Health Coverage Gaps*, 15 (Berkeley Center on Health, Economic & Family Security, 2009), http://www.law.berkeley.edu/files/chefs/Effect_of_Reform_on_Gap_Groups.pdf.).

Many of the provisions of the ACA quickly added value to CalPERS members' health benefits and reduced the costs of care. Absent a minimum essential coverage requirement, the "individual mandate," Congress' attempt to control the cost of

care will be severely undermined. Without this requirement, the real costs of health care services used by uninsured individuals will continue to be borne by health care providers, insurers and to a great extent their insureds – including CalPERS employers and members. These costs will be passed on through higher premiums and other costs of care ultimately paid through commercial insurance. As an essential part of the ACA, the individual mandate will support other reforms in the Act by requiring individuals to obtain health coverage, which will increase preventive care and therefore lower the overall cost of health care.

ARGUMENT

I. THE AFFORDABLE CARE ACT CREATES A NATIONAL SOLUTION TO THE HEALTH CARE CRISIS

The ACA is built upon the principle of cooperative federalism. This principle "leaves to the States the primary responsibility for developing and executing" programs, but sets "requirements to be followed in the discharge of that responsibility." *Schaeffer v. Weast*, 546 U.S. 49, 52 (2005). Thus, Congress encourages rather than prevents "the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise." *U.S. v. Lopez*, 514 U.S. 549, 583 (1995).

The ACA is part of a long history of cooperative federalism in the field of health insurance and health care, starting with the creation of Medicare and Medicaid in 1965 and more recently

with the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996. Key features of the ACA include the following: (i) granting states the authority to establish and design health insurance exchanges, where individuals and small businesses can purchase coverage in lieu of a federal health exchange; (ii) granting states the authority to establish basic health programs for low-income individuals who are Medicaid eligible; and (iii) expanding Medicaid funding and awarding grants to states to develop *innovative* approaches to insure their residents. Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (emphasis added).

These changes are designed to improve and stabilize the health care insurance market, where CalPERS purchases insurance coverage on behalf of participating employers and members.

A. CalPERS Role as a Purchasing Agent of Health Care Benefits

In 1961, the California Legislature enacted PEMHCA, entrusting the administration of the program to the CalPERS Board of Administration (Board).[2] Under PEMHCA, CalPERS provides health benefits to state, contracting public agency, and school district employees, annuitants and family members, including the employee's or retiree's spouse or domestic partner, and natural, step, and adopted children. Cal. Gov't Code, §§22800 and 22775 (LexisNexis 2011). Today, CalPERS health

[2] At the time of enactment, PEMHCA was titled the Meyers-Geddes Employees' Medical and Hospital Care Act. See Cal. Gov't. Code, § 22750.

plans insure 1.3 million members. In 2011, CalPERS spent more than $ 6.67 billion to purchase health benefits for those members. *CalPERS Facts at a Glance*, (December 2011) http://www.calpers.ca.gov/eip-docs/about/facts/health.pdf.

As part of its responsibilities under PEMHCA, CalPERS enters into contracts with carriers offering health benefit plans and with entities offering services relating to the administration of health benefit plans. *Id.,* at §22850(a). CalPERS plans include hospital, surgical, inpatient medical, outpatient, and obstetrical benefits. Cal. Gov't Code § 22850(b). Additionally, the Board has authority to contract for or implement employee cost containment and reduction incentive programs. *Id.,* at §22850(e).

Since the enactment of PEMHCA, CalPERS has worked with contracted health plans to implement benefit plan designs that offer appropriate health care services at low cost to employers, employees, and annuitants receiving benefits under PEMHCA. Each year, the Board negotiates with contracted health plans to set premium rates for the upcoming calendar year. In negotiating these agreements, the Board acts as the agent or representative of the employees. *Madden v. Kaiser Found. Hosps.*, 17 Cal.3d at 705. Benefit design components aimed at curbing the cost of care in recent years include incentivizing members to utilize certain "value based purchasing centers" through favorable co-pays and co-insurance fees, requiring members to pay the difference between a brand name drug and its generic alternative, and encouraging the use of ambulatory care centers over outpatient hospital settings for particular surgeries through increased co-pays for non-optimal settings.

See Doug McKeever, *Health Benefits Committee Agenda Item 4a*, (June 14, 2011), http://www.calpers.ca.gov/eip-docs/about/board-cal-agenda/agendas/hbc/201106/item-4a.pdf.

CalPERS also plays a signficant role in the development of health policy throughout the State of California. CalPERS works with health plans to encourage hospitals to lower costs, and uses its contracting power to exclude providers and hospitals that refuse to lower overhead and other variable costs. See *CalPERS drops 38 Hospitals from Health Network to Trim Spending*, Associated Press (LexisNexis, May 19, 2004). Additionally, the CalPERS Government Affairs Unit monitors health care legislation and represents CalPERS before the California Legislature.

Prior to enactment of the ACA, CalPERS supported implementation of federal health care reform. Once the ACA became law, CalPERS began to implement the new requirements through contract negotiation, statutory and regulatory changes, and updates to member materials and changes to internal policies and practices.

B. Early Retiree Reinsurance Program

Congress recognized that rising costs have made it difficult for employers to provide quality, affordable health insurance for workers and retirees while also remaining competitive in the global marketplace. *The Affordable Care Act's Early Retiree Reinsurance Program*, HealthCare.gov (October 4, 2010),http://www.healthcare.gov/news/factsheets/2010/10/early-retiree-reinsurance-program.html. Many Americans who retire without employer-

sponsored insurance and before they are eligible for Medicare have experienced severe financial pressures in obtaining health insurance in the individual market. Id. The Early Retiree Reinsurance Program (ERRP) was enacted to provide financial relief for employers. Affordable Care Act, Pub. L. No. 111-148, §1102(a)(1), 124 Stat. 143 (2010). Under ERRP, for each early retiree enrolled in a certified plan in a plan year, the ERRP plan sponsor receives reimbursement in the amount of 80 percent of the costs for health benefits for claims incurred during the plan year, and paid by the employment-based plan, and by the early retiree. 45 CFR 149.100 (2010).

As of December 2, 2011, the federal government has disbursed over $4.5 billion in ERRP funding to a variety of businesses, including for-profit companies, schools and educational institutions, unions, state and local governments, religious organizations and other nonprofit Plan Sponsors, to help reduce their health plan benefit costs and those of their plan participants. *Update on ERRP Payment Processing and Announcement of End Date for Newly Incurred Claims*, ERRP.gov, (December 9, 2011), http://www.errp.gov/newspages/20111209-updated-payment-processing-new-incurred-date.shtml. To request reimbursement funding, CalPERS was required to participate in an extensive application process. 45 CFR 149.40 (2010). As part of this process, CalPERS worked with each health plan to put in place the required information sharing agreements, gather claims data for early retirees and their dependents, and to ascertain accurate Social Security numbers for each individual. To date, CalPERS has received over $98 million in

ERRP funds. This money was used to offset premium increases for plan years 2011 and 2012 across all CalPERS health plans, reducing premiums by two to three percent. Stephen Huth, *Availability of Early Retiree Reinsurance Program Ends In May 2011*, CCH Aspen Publishers Tech. Answer (April 2011),http://healthcarelegislation.blogspot.com/2011/04/availability-of-early-retiree.html.

C. Increase in Dependent Coverage Age

The ACA also requires private insurers that offer dependent coverage to children to allow young adults up to age 26 to remain on their parent's insurance plan. Affordable Care Act, Pub. L. No. 111-148, §2714(a), 124 Stat. 132 (2010). To date, it has been estimated that as a result of this change in the law, 2.5 million young adults between the ages of 19 and 25 have gained health insurance coverage. *New data: Affordable Care Act helps 2.5 million Add'l Young Adults Get Health Ins.*, U.S. Dep't. of Health and Human Servs,, HHS.gov, (December 14, 2011), http://www.hhs.gov/news/press/2011pres/12/20111214d.html

Prior to the enactment of the ACA, CalPERS health plans covered unmarried dependents up to age 23 under a parent's health plan. In February 2011, CalPERS filed amended regulations with the California Secretary of State that increased the dependent coverage age limit to 26, and removed any additional eligibility requirements, other than parental status, consistent with new federal requirements. Beginning with open enrollment in Fall 2010, CalPERS members enrolled approximately 28,000 young adults as a result of

these changes for coverage in plan year 2011. CalPERS also worked with other California agencies, including the State Controller's Office and Franchise Tax Board, to implement conforming state tax laws to exempt these benefits from a parent's stated income.

D. Increased Service Levels to Members

In accordance with the ACA, CalPERS also eliminated lifetime limits for speech therapy and hospice care for self-funded plans effective January 1, 2011. This has resulted in increased service levels for CalPERS members. Affordable Care Act, Pub. L. No. 111-148, §2711(a), 124 Stat. 131 (2010).

E. Federal Regulatory Implementation

CalPERS routinely tracks the various proposed federal regulations implementing the provisions of the ACA, assesses the impact of these regulations on CalPERS health plans and benefit design, and provides comments to the appropriate implementing agency when warranted. As a result of the ACA, CalPERS has changed many policies and procedures to comply with these regulations. Notable among these new regulations is the requirement that all health benefit plans, including self-funded plans, provide an independent, external review of denied claims involving medical judgment. This required CalPERS to amend its contractual arrangements with the third party administrators of its PPO plan and pharmacy benefits, as well as amend explanatory documents provided to members.

F. Implementation of the Affordable Care Act Demonstrates Cooperative Federalism

The ACA continues the model of joint participation of the state and federal governments to address critical issues facing the nation as a whole. The ACA explicitly provides the states with opportunities to be innovative to address the critical issue of ensuring that every citizen has health insurance coverage. Through its implementation efforts, CalPERS has made substantial changes in the health benefits provided to its membership through changes in state statutes and regulations and through changes in the relationships with its contracting health care providers.

II. THE INDIVIDUAL MANDATE IS ONE OF MANY "ESSENTIAL PARTS" OF CONGRESS' CONSTITUTIONAL REGULATION OF THE HEALTH CARE SERVICES MARKET

"Case law firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 17 (2005). By passing the ACA, Congress sought to regulate an ever-increasing segment of the United States economy by encouraging participation in the system, increasing accessibility, and lowering the overall cost of health care. See Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). An integral part of this regulatory scheme is the "individual mandate," by

which Congress seeks to regulate economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. *Id.,* at 119 Stat. 242. Incremental attempts to solve the uninsured crisis on a state-by-state basis have been largely unsuccessful, as illustrated by California's numerous legislative efforts to lower the uninsured rate of 21%. Gardner, *supra*, at 1. Trying to achieve the large scale funding required for health care reform at the state level has been a losing proposition: "The single biggest problem for states to overcome with respect to any expensive wholesale reform is the perpetual boom-bust fiscal cycle from surplus to deficit and back again that derails large scale funding . . .." Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage?* 6 (Jan. 2, 2011, 6:45 a.m.) http://works.bepress.com/susan_channick/1. The individual mandate is an essential part of the overall scheme developed by Congress to mitigate impacts of rising health care costs to the national economy.

A. The Decision Not to Purchase Health Insurance Substantially Affects Interstate Commerce

In *Wickard v. Filburn*, this Court held that whatever its nature, Congress may reach an intrastate activity if it exerts a substantial economic effect on interstate commerce. *Wickard v. Filburn*, 317 U.S. 111, 63 (1942) (cited in *Gonzales v. Raich*, 545 U.S. at 18, as being of "particular relevance" in assessing "Congress' power to regulate purely local activities that are part of an economic class of activities that have a substantial effect on interstate

commerce."). Filburn, a farmer in Ohio, planted 23 acres of wheat in 1941 -- 11.9 acres over the limit imposed by Congress by way of the Agriculture Adjustment Act of 1938. He challenged the regulation on the ground that Congress overstepped its Commerce Clause authority when it interfered with his strictly intrastate activity – producing additional wheat for consumption on his own farm. *Id.,* at 114-115 (italics added). The Court denied his challenge and held that Filburn's decision to use home-grown wheat, rather than participate in the interstate market for wheat, had a substantial effect on the ability of Congress to control the price and supply of wheat in an extremely volatile market. *Id.,* at 127. The Court reasoned that stimulation of commerce was an appropriate use of Congress' regulatory power, as was the power to regulate prices at which commodities are dealt. The variable nature of a farmer's actions in regard to home-grown wheat interfered with the efforts of Congress to control the supply and market price of wheat. *Id.,* at 128-129. The Court reasoned that while Filburn's own contribution to the demand for wheat "may be trivial by itself, it is not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many other similarly situated, is far from trivial." *Id.,* at 127-128.

Like Filburn's decision to use home-grown wheat rather than to purchase it on the open market, an individual's decision not to participate in the health insurance market, taken in the aggregate with other individuals making similar decisions, substantially affects Congressional attempts to control the cost of health care. The ACA's individual mandate is aimed at individuals who make a

deliberate choice not to purchase health insurance. This decision, or "activity," is analogous to Filburn's decision to grow and use 11.9 additional acres of wheat for his own consumption. Similar to Filburn's decision not to buy additional wheat on the open market, the uninsured's decision to access the health care system without paying for the cost of health services through insurance is a factor of volume and variability that wields a substantial influence on the price and market conditions of health care services. Compare *Wickard*, 317 U.S. at 128. The Court in *Wickard* understood that while Filburn's decision in 1941 was to forego participation in interstate commerce, in other years he may decide to introduce the additional wheat into the market, if high prices induced him to sell instead of consume the wheat. *Id.,* at 128. Similarly, uninsured individuals enter the market in an unpredictable and irregular fashion – accessing the system only at the point of acute need (for example, through emergency room visits). This variability substantially affects the health insurance and services market and makes it difficult for Congress to control the price and volume of services.

CalPERS benefit designs, as well as the ACA, also include provisions that encourage individuals to access health care services on a preventive basis, thus lowering the cost-of-care over the long term. Conversely, because they are required to pay on a fee-for-service basis, uninsured individuals often forego routine preventive medical services, and access the health care system only when they have a more costly medical need. See *"Coverage Matters," America's Uninsured Crisis*, The Nat'l Academies Press, (2009), http://www.nap.edu/openbook.php?record_id=12511&page=49.

An example of this higher cost care is the uninsured accessing health care services through the emergency room. In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires all participating hospitals to provide care to anyone needing emergency health care services regardless of citizenship, legal status or ability to pay. 42 U.S.C. § 1395dd. Participating hospitals are those that accept payment from the Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) under the Medicare program. Practically speaking, EMTALA applies to virtually all hospitals in the United States. There are no reimbursement provisions in EMTALA to cover the cost for emergency care that participating hospitals are obligated to provide. Accessing care on an emergency basis increases costs because the individual may not be able to afford the immediate expense, because emergency care is typically more expensive than routine provider care, and because of the higher cost of caring for more advanced stages of illness. Costs that go unpaid by uninsured individuals get passed on to the insured by hospitals and providers through increased costs for services, and ultimately through premium increases and other cost-sharing plan designs.

As a purchaser, CalPERS is impacted by the substantial effect of the uninsured on the health care market by way of increased premiums and out-of-pocket expenses for CalPERS members. In 2006, it was estimated health insurance premiums in California for a family with private, employer-sponsored coverage were $1,186 higher due to the unpaid cost of health care for the uninsured. This figure was $455 higher for individual health

insurance coverage in the state. 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 (December 2006). These figures were estimated to rise to $1,792 and $521 respectively by 2010. Paying a Premium: The Added Cost of Care for the Uninsured, A Report by Families USA (June 2005). Cost-shifting due to uncompensated costs of the uninsured exerts a substantial economic effect on interstate commerce as evidenced by increased premiums for all health insurance plans offered by CalPERS. CalPERS premiums for all plans increased by an average of 9.64% each year from 1998 to 2010. See CalPERS Health Benefits Program Total Plan Changes, 1998-2012, (June 2011), Appendix p. 7a. During this same period, general inflation averaged just 2.38% per year. *Historical Inflation Rates: 1914 – 2011, US Inflation Calculator*, (Jan. 11, 2012, 11:30 a.m.), http://www.usinflationcalculator.com/inflation/historical-inflation-rates/

In addition, 55,619 CalPERS members reside outside California and receive health benefits provided under CalPERS self-funded health plan. CalPERS HMO members access health care services when traveling out-of-state under the provisions of their particular plan. Claims submitted by these members are based on the cost of care in the states in which they live or visit. As uninsured individuals access care in any given state, those costs are shifted to paying consumers through increased premiums as well as increased costs of services from providers and hospitals. Even if CalPERS can to some extent control the more immediate shifting of these costs to the State of California and agency employers by way

of coverage limitations and co-pays, CalPERS out-of-state members bear the impact of cost-shifting.

The attempt by Congress through the ACA to control the manner in which individuals access the health care market – by spreading the cost of an individual's access over time – is a legitimate use of Congressional power to regulate the interstate commerce of health care services. The individual mandate requires uninsured individuals to enter the market earlier than they chose to under the current system, at the time they are in acute need of care. In this respect, the individual mandate allows Congress to control a variable factor of health care cost that substantially impacts its ability to regulate the health care market.

B. The Individual Mandate Constitutionally Regulates an Economic Activity and is a Rational Means of Regulating Interstate Commerce in Health Insurance and Services.

As an essential part of a larger regulation of economic activity, the individual mandate provision in the ACA is rationally related to the objectives of that broader statutory scheme. In *Gonzales v. Raich*, the Court held Congress acted within its Commerce Clause authority when it regulated the intrastate production and sale of marijuana through the Controlled Substances Act (CSA). 545 U.S. 1 (2005). The Court reasoned that, as in *Wickard*, the primary purpose of the CSA was to control the supply and demand of a product, and that Congress had a rational basis for concluding that leaving home-consumed marijuana outside federal control would similarly affect price and market conditions. *Id.,* at

19. "In assessing the scope of Congress' authority under the Commerce Clause…[w]e need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Id.,* at 22.

The *Raich* Court distinguished both *U.S. v. Lopez* and *U.S. v. Morrison*, earlier cases that invalidated Congressional regulations on the grounds the intrastate activities subject to regulation had nothing to do with "any sort of economic enterprise, however broadly one might define those terms." *Id.,* at 24, (quoting *U.S. v. Lopez*, 514 U.S., at 561.)

In *U.S. v. Lopez*, the Court held the Gun Free School Zones Act, which assigned criminal penalties for possessing a gun in a school zone, was an unconstitutional expansion of Congressional power under the Commerce Clause because possession of a gun in a local school zone was "in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce." *U.S. v. Lopez*, 514 U.S. at 567. The Court stated that to uphold the law, it would have to "pile inference upon inference" to find a nexus with interstate commerce, where the government cited the potential increase in insurance premiums resulting from "violent crime" and the inhibition of interstate travel when citizens feel a particular location is overly dangerous as impacts of the activity on interstate commerce. *Id.,* at 567. The majority reasoned that if this attenuated connection were permitted to justify Congress' action, there was no limit to Congress' powers under the Commerce Clause. *Id.,* at 564.

Similarly, in *U.S. v. Morrison*, the Supreme Court held the Violence Against Women Act of 1994 was unconstitutional because Congressional reasoning linking violence against women to interstate commerce via travel deterrence and impacts to national productivity posed a "but-for causal chain from the initial occurrence of a violent crime to every attenuated effect upon interstate commerce." 529 U.S. 598, 615 (2000). Allowing Congress to use such attenuated reasoning, the Court held, would allow Congress to regulate any crime as long as the nationwide, aggregated impact of that crime has substantial effects on employment, production, transit, or consumption. *Id.,* at 615.

Unlike those activities at issue in *Lopez* and *Morrison*, the activities regulated by the CSA were quintessentially economic. *Raich*, 545 US at 25. While respondents in *Raich* argued the decisions in *Lopez* and *Morrison* required that the CSA be held unconstitutional, the Court compared the statutes at issue in the three cases and determined the *Lopez* and *Morrison* regulations were "markedly different." *Id.,* at 23. "Where the class of activities is regulated and that class is within the reach of federal power, the courts have no power 'to excise, as trivial, individual instances of the class." *Id.,* at 23, (citations omitted). Because the CSA was a statute that directly regulated economic, commercial activity, the Court stated that its opinion in *Morrison* cast no doubt as to its constitutionality." *Id.,* at 26.

Like wheat production and consumption in *Wickard*, and marijuana production and possession in *Raich*, the decision not to purchase health care insurance is a "quintessentially economic" decision. First, the uninsured as a class are active in the

market for health care, which they regularly access through different means. The minimum coverage provision merely regulates how individuals finance and pay for that active participation—requiring that they do so through insurance, rather than through attempted cost-shifting. See *Thomas More Law Center v. Obama*, 651 F.3d 557, 561 (Sutton, J.) ("No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action addressing the same risk."). Therefore, Congress had a rational basis for believing that failure to regulate the uninsured would "leave a gaping hole" in the ACA. See *Raich*, 545 U.S. at 22.

The connection between the uninsured population and the national cost of health care to the U.S. economy has been well-established by Congressional findings and national data. See Affordable Care Act, Pub. L. No. 111-148, §1501(a), 124 Stat. 242 (2010). In 2008, health care providers absorbed $43 billion in uncompensated care costs for providing care for the uninsured. *Id.* Congress found overall health care spending in 2009 was approximately $2.5 trillion, or 17.6% of the national economy. *Id.* Private health insurance accounted for 32% of this spending, which involved private employer-based insurance plans and the private individual health insurance market. *National Health Expenditure Data Fact Sheet*, Centers for Medicare and Medicaid Services (CMS), (January 6, 2012), https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp.

Approximately 200 million people in the U.S. are covered under the private health insurance system. *Income, Poverty, and Health Insurance*

Coverage in the United States: 2010, (September 2011), http://www.census.gov/prod/2011pubs/p60-239.pdf. Moreover, in 2010 an additional 47.5 million individuals obtained health insurance coverage through the Medicare program. As of 2009, 47.8 million people in the country were covered under the Medicaid program. *Fast Facts About Medicare*, National Committee to Preserve Social Security and Medicare, (Jan. 12, 2012, 10:42 a.m.), http://www.ncpssm.org/fasfactm and *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, (September 2011), http://www.census.gov/prod/2011pubs/p60-239.pdf. In California an estimated 6.7 million individuals, or 21.5% of the California population, are uninsured. *California's Uninsured, Cal. Health Care Almanac*, Cal. Health Care Found., p. 3-4 (December 2011). This includes individuals who could but do not access safety net programs such as Medicaid and Healthy Families, (up to 76% of California's uninsured children) and 23.7% of employed individuals. *Id.,* at 8, 16.

For the reasons outlined above, Congress rationally determined that regulation of the uninsured population was a required part of the overall regulatory scheme to lower health care costs and increase individual access to care.

CONCLUSION

This Court should uphold the Patient Protection and Affordable Care Act as a constitutional exercise of Congressional power under the Commerce Clause. The judgment of the Eleventh Circuit Court of Appeals invalidating the minimum coverage provision should be reversed.

RESPECTFULLY SUBMITTED,

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Employees'
Retirement System

January 13, 2012

APPENDIX

1. Cal. Gov't Code, § 22750 provides:

   This part may be cited as the Public Employees' Medical and Hospital Care Act. As used in any contract or statute, the term "Meyers–Geddes State Employees' Medical and Hospital Care Act" shall be construed to refer to and mean the Public Employees' Medical and Hospital Care Act.

2. Cal. Gov't Code, § 22751 provides:

   It is the purpose of this part to do all of the following:

   (a) Promote increased economy and efficiency in state service.

   (b) Enable the state to attract and retain qualified employees by providing health benefit plans similar to those commonly provided in private industry.

   (c) Recognize and protect the state's investment in each permanent employee by promoting and preserving good health among state employees.

3. Cal. Gov't Code, § 22775 provides:

   "Family member" means an employee's or annuitant's spouse or domestic partner and any child, including an adopted child, a stepchild, or recognized natural child. The board shall, by regulation, prescribe age limits

and other conditions and limitations pertaining to children.

4. Cal. Gov't Code, § 22800 provides:

Enrollment of employee or annuitant; Exclusion of certain employees

(a) An employee or annuitant is eligible to enroll in an approved health benefit plan, in accordance with this part and the regulations of the board.

(b) Regulations may provide for the exclusion of employees on the basis of the nature, conditions, and type of their employment, including, but not limited to, short–term appointments, seasonal or intermittent employment, and employment of a like nature. However, no employee may be excluded solely on the basis of the hazardous nature of the employment.

5. Cal. Gov't Code, § 22850 provides:

Contracts for health benefit plans not subject to competitive bidding; Powers of board; Services offered; Cost containment and cost reduction incentive programs; Approval of certain preexisting plans

(a) The board may, without compliance with any provision of law relating to competitive bidding, enter into contracts with carriers offering health benefit plans or with entities offering services

relating to the administration of health benefit plans.

(b) The board may contract with carriers for health benefit plans or approve health benefit plans offered by employee organizations, provided that the carriers have operated successfully in the hospital and medical care fields prior to the contracting for or approval thereof. The plans may include hospital benefits, surgical benefits, inpatient medical benefits, outpatient benefits, obstetrical benefits, and benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means.

(c) Notwithstanding any other provision of this part, the board may contract with health benefit plans offering unique or specialized health services.

(d) The board may administer self–funded or minimum premium health benefit plans.

(e) The board may contract for or implement employee cost containment and cost reduction incentive programs that involve the employee, the annuitant, and family members as active participants, along with the carrier and the provider, in a joint effort toward containing and reducing the cost of providing medical and hospital health care services to public employees. In developing these plans, the board, in cooperation with the Department of Personnel

Administration, may request proposals from carriers and certified public employee representatives.

(f) Notwithstanding any other provision of this part, the board may do any of the following:

(1) Contract for, or approve, health benefit plans that charge a contracting agency and its employees and annuitants rates based on regional variations in the costs of health care services.

(2) Contract for, or approve, health benefit plans exclusively for the employees and annuitants of contracting agencies. State employees and annuitants may not enroll in these plans. The board may offer health benefit plans exclusively for employees and annuitants of contracting agencies in addition to or in lieu of other health benefit plans offered under this part. The governing body of a contracting agency may elect, upon filing a resolution with the board, to provide those health benefit plans to its employees and annuitants. The resolution shall be subject to mutual agreement between the contracting agency and the recognized employee organization, if any.

(g) The board shall approve any employee association health benefit plan that was approved by the board in the 1987–88 contract year or prior, provided the plan continues to meet the minimum standards prescribed by the board. The trustees of an employee association health benefit plan are responsible for providing health benefit plan administration and services to its enrollees. Notwithstanding any other provision of this part, the California Correctional Peace Officer Association Health Benefits Trust may offer different health benefit plan designs with varying premiums in different areas of the state.

(h) Irrespective of any other provision of law, the sponsors of a health benefit plan approved under this section may reinsure the operation of the plan with an admitted insurer authorized to write disability insurance, if the premium includes the entire prepayment fee.

6. Title 2, California Code of Regulations § 599.500, states in pertinent part:

(n) A "child," as described in Government Code section 22775, means an adopted, step, or recognized natural child until attainment of age 26, unless the child is disabled as described in section 599.500, subdivision (p).

(o) In addition to a "child" as described in Government Code section 22775, "family

member" also includes any child for whom the employee or annuitant has assumed a parent-child relationship, in lieu of a parent-child relationship described in subdivision (n), as indicated by intentional assumption of parental status, or assumption of parental duties by the employee or annuitant, as certified by the employee or annuitant at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled as described in section 599.500, subdivision (p). This section should not be construed to include foster children.

(p) "Disabled child," means a child, as described in Government Code section 22775 and section 599.500, subdivision (n) or (o), who at the time of attaining age 26, is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 and who is enrolled pursuant to section 599.501, subdivisions (f) and (g), until termination of such incapacity.

CalPERS Health Benefits Program

Total Basic Plan Changes (by type)															
Heath Plan Type Category	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Overall Basic	3.2%	6.1%	9.2%	11.8%	9.6%	24.1%	16.42%	9.93%	8.88%	11.91%	6.78%	4.84%	3.24%	9.94%	4.61%
HMOs	2.7%	7.3%	9.7%	9.2%	6.0%	25.9%	17.97%	11.38%	8.70%	11.60%	7.39%	6.57%	3.43%	10.61%	5.30%
Self-Funded PPOs	5.3%	1.3%	8.0%	21.7%	19.8%	19.9%	13.18%	6.40%	9.49%	12.61%	4.15%	-0.04%	3.29%	8.70%	3.04%
Association Plans	3.5%	2.6%	4.0%	12.8%	14.4%	20.8%	11.62%	6.75%	8.27%	12.76%	10.81%	4.98%	0.93%	7.19%	2.66%

Total Medicare Plan Changes (by type)															
Heath Plan Type Category	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Overall Medicare	6.6%	11.1%	26.7%	25.4%	16.0%	17.8%	10.04%	-11.32%	6.96%	13.48%	3.03%	0.73%	1.11%	3.38%	0.05%
HMOs	5.2%	18.8%	70.1%	31.7%	16.5%	40.6%	26.75%	-10.74%	-7.01%	24.98%	-1.61%	1.64%	0.27%	0.16%	-0.94%
Self-Funded PPOs	7.2%	9.3%	13.6%	22.7%	15.9%	5.8%	-1.21%	-12.52%	18.63%	6.77%	6.67%	0.00%	1.68%	5.59%	0.73%
Association Plans	1.8%	2.3%	20.7%	13.5%	10.5%	18.8%	14.98%	0.53%	0.00%	0.23%	-2.27%	1.31%	2.50%	4.22%	0.86%

Combined (Basic and Medicare Combined) Plan Changes (by type)															
Heath Plan Type Category	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Combined Overall	3.5%	6.6%	11.0%	13.4%	10.5%	23.3%	15.59%	7.14%	8.65%	12.10%	6.32%	4.34%	2.99%	9.13%	4.05%
Combined HMOs	3.0%	8.5%	11.7%	10.4%	6.7%	26.9%	18.65%	9.48%	7.53%	12.50%	6.69%	6.21%	3.20%	9.82%	4.84%
Combined PPOs	5.5%	2.1%	9.9%	22.0%	18.7%	16.1%	9.56%	1.76%	11.51%	11.19%	4.74%	-0.03%	2.90%	7.91%	2.45%
Combined Assoc. Plans	3.3%	2.6%	5.0%	12.9%	14.1%	20.6%	11.84%	6.32%	7.72%	11.97%	10.06%	4.79%	1.01%	7.03%	2.56%