No. 11-398

In the Supreme Court of the United States

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,

v.

STATE OF FLORIDA, ET AL.,
Respondents.

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

BRIEF OF *AMICUS CURIAE*, COMMONWEALTH OF MASSACHUSETTS

(SUPPORTING PETITIONERS AND ADDRESSING WHETHER ENACTING MINIMUM COVERAGE PROVISION OF ACA AUTHORIZED BY ARTICLE I)

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QUESTION PRESENTED

Beginning in 2014, the minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, will require non-exempted individuals to maintain a minimum level of health insurance or pay a tax penalty. 26 U.S.C.A. 5000A. The question presented is:

Whether Congress had the power under Article I of the Constitution to enact the minimum coverage provision?

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INTEREST OF THE AMICUS CURIAE[1]

In the spring of 2006, the Commonwealth of Massachusetts passed and implemented *An Act Providing Access to Affordable, Quality, Accountable Health Care*, Chapter 58 of the Acts of 2006 ("Chapter 58"), thereby becoming the first State in the Nation to enact healthcare reform that requires all non-exempt individuals to purchase some form of health insurance coverage. Chapter 58's core features include, among other things, a state-operated health insurance exchange, new subsidies for low- and moderate-income individuals, and a mandate that all individuals who can afford health insurance purchase coverage. Chapter 58 has been widely cited as a model used by Congress in fashioning what became the Patient Protection and Affordable Care Act (the "ACA").

With four years of empirical data collected since Chapter 58 went into effect, Massachusetts is uniquely situated to speak to the actual economic effects of comprehensive reform that includes an individual coverage requirement.

The experience of Massachusetts under Chapter 58 confirms a key Congressional assumption underlying the ACA: that by requiring individuals to be insured, and thereby preventing healthy people from foregoing

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[1] Pursuant to Rule 37.4 of the Rules of this Court, the Commonwealth of Massachusetts, as a sovereign State, does not require leave to file this amicus curiae brief submitted by its Attorney General. This brief was not written in whole or in part by counsel for any party, and no person or entity other than the amicus curiae has made a monetary contribution to the preparation and submission of this brief.

health insurance until they are sick or injured (a practice often described as "free-riding"), a comprehensive reform program can spread risk, control costs, and reduce the financial burdens otherwise borne by health plans and free-care pools. Massachusetts submits this amicus brief in support of the ACA because its experience demonstrates that Congress had a rational basis for concluding that free-riding by individuals, taken in aggregate, has a substantial effect upon interstate commerce, and that reducing or eliminating free-riding has a salutary impact on the health insurance market as a whole.

In July of 2005, then Governor Mitt Romney filed House Bill 4279, and in his filing letter to the Massachusetts Legislature he stated:

> Today, we spend approximately $1 billion on the medical cost for the uninsured. Safety Net Care redirects this spending to achieve better health outcomes in a more cost-effective manner. With Safety Net Care in place, it is fair to ask all residents to purchase health insurance or have the means to pay for their own care. This personal responsibility principle means that individuals should not expect society to pay for their medical costs if they forego affordable health insurance options.[2]

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[2] Letter from Governor Mitt Romney to the Massachusetts Legislature dated July 20, 2005, filing *An Act to Increase the Availability and Affordability of Private Health Insurance To Residents of the Commonwealth*. H.B. 4279, 184th Gen. Ct. (Mass. 2005).

Governor Romney's proposed legislation to enact "Safety Net Care" was the precursor to Chapter 58, which he signed on April 12, 2006.[3]

The Massachusetts healthcare reform law has yielded positive economic consequences. Since its enactment, Massachusetts has reduced the number of uninsured residents to less than two percent of the State's population, giving Massachusetts the lowest percentage of uninsured residents in the Nation.[4] The significant gains in the number of Massachusetts residents with health insurance helped spur a corresponding sharp decline in spending by the state's "free care" pool for the uninsured and under-insured. The dollar value of free care provided dropped from $709.5 million in fiscal year 2006 to $475 million in fiscal year 2010.[5]

Despite these successes under Chapter 58, Massachusetts, like any individual State, is unable to

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[3] Under Governor Romney's proposed legislation, "Safety Net Care" was the term used for a proposed government- subsidized premium assistance offered to low-income individuals who were not eligible for Medicaid. H.B. 4279, 184th Gen. Ct. (Mass. 2005).

[4] See Mass. Division of Health Care Finance and Policy, Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys 1 (Dec. 2010), available at http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/10/mhis-report-12-2010.pdf [hereinafter Mass. Health Insurance Survey Results].

[5] See Mass. Division of Health Care Finance and Policy, Health Safety Net 2010 Annual Report 4 (Dec. 2010); Mass. Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report 3 (July 2007).

grapple effectively with the interstate (and international) economic implications of current healthcare trends. While Massachusetts plays the primary role in protecting the health and welfare of Massachusetts residents, the State shares responsibility for regulating healthcare and health insurance with the federal government. Through Medicare, Medicaid, and a variety of federal statutes, notably the Employee Retirement Income Security Act of 1974 ("ERISA"),[6] the federal government plays a substantial (and, in some areas, exclusive) role in shaping the nationwide healthcare marketplace. Given this overlay, some aspects of healthcare reform are beyond individual states' regulatory reach. For example, Massachusetts's ability to regulate the private group health plan market in Massachusetts is constrained by ERISA, which preempts state governments from enacting laws that regulate self-insured employer health benefit plans, the most common source of health coverage for American workers.

Accordingly, Massachusetts supports the ACA as an appropriate federal response to the urgent need for comprehensive, national healthcare reform. The ACA carefully balances federal economic interests with the States' interests in developing new ways to control costs while improving access to quality healthcare.

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[6] Pub. L. No. 93-406, § 2.

SUMMARY OF ARGUMENT

Having enacted six years ago a prototype of the comprehensive healthcare reform package that Congress would later adopt in 2010, Massachusetts is in a unique position to assess the rationality of the assumptions that underlay both enactments.

Specifically, the Court has held that the Commerce Clause empowers Congress to regulate activities that substantially affect interstate commerce. Congress properly exercised that power in adopting a provision in the ACA that requires all non-exempt persons to purchase at least a minimum level of health insurance coverage. Through its legislative findings, Congress rationally concluded that those who fail to purchase health insurance despite their ability to pay for it ("free riders") not only drain finite State and federal free-care resources, but also negatively impact the availability of privately-issued health insurance policies and the prices at which such policies are sold. Congress further concluded that curtailing the practice of "free riding" would make private health insurance coverage easier for individuals both to procure and to afford.

Having examined data for four years following the adoption of its own individual mandate, Massachusetts can attest to the rationality of Congress's conclusions. Massachusetts now finds that its efforts to stop healthy people from opting out of purchasing health insurance have increased health-plan enrollment and helped decrease the rate of premium growth. These developments, in turn, prompted a significant reduction in governmental and private free-care expenditures. Because Massachusetts's empirical

experience demonstrates a strong link between eliminating "free riders" and improving access (and reducing costs), Congress acted rationally in drawing the same link as one basis for its regulation of activity affecting interstate commerce. (Pages 7 to 11.)

The Massachusetts experience further demonstrates that Congress was also empowered to enact an individual mandate under the Necessary and Proper Clause. That clause authorizes Congress to take the steps necessary to implement legislation that falls within a specifically enumerated power. Thus, even if an individual mandate did not fall within the ambit of the Commerce Clause, the broader machinery of the ACA -- provisions broadening access, controlling costs, and eliminating denials based on pre-existing conditions -- was constructed precisely to regulate the interstate features of the health insurance marketplace. That attacking the "free rider" problem is rationally related to achieving the ACA's interstate-commerce objectives likewise finds strong support in the Massachusetts data. (Pages 12 to 14.)

Finally, while Massachusetts has reaped many benefits as a pioneer in healthcare reform, its experience also demonstrates the limitations on a single State, acting alone. Many aspects of health insurance are the exclusive domain of federal regulators, while innovations by individual States have consequences beyond that State's borders. This demonstrates both the interstate character of the health insurance market and the need for a coherent federal approach to its regulation. (Pages 15 to 17.)

ARGUMENT

I. THE ECONOMIC EFFECTS OF THE MASSACHUSETTS INDIVIDUAL MANDATE CONFIRM THAT CONGRESS HAD A RATIONAL BASIS TO DETERMINE THAT FREE-RIDING, TAKEN IN AGGREGATE, SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE

The Commerce Clause provided Congress with authority to enact the ACA, including the minimum coverage requirement. The Constitution gives Congress the power to "regulate Commerce . . . among the several States." U.S. Const., art. I, § 8, cl. 3. Under this authority, Congress can "regulate activities that substantially affect interstate commerce." Gonzales v. Raich, 545 U.S. 1, 17 (2005).[7]

As "stressed" by this Court, "[i]n assessing the scope of Congress' authority under the Commerce Clause . . . the task before [the Court] is a modest one." Id. at 22. The Court "need not determine" itself whether the regulated "activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." Id.

There is a rational basis for concluding that, taken in the aggregate, individuals' refusal to obtain health

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[7] Congress also has the authority to "regulate the channels of interstate commerce" and to "regulate and protect the instrumentalities of interstate commerce and persons or things in interstate commerce." Gonzales, 545 U.S. at 16-17.

insurance substantially affects interstate commerce. "[T]he business of insurance" is within "the regulatory power of Congress under the Commerce Clause." United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 553 (1944). In the ACA, Congress found that:

> The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

ACA § 1501(a)(2)(F), as amended by § 10106.[8] "It is well established by decisions of the Court that the power to regulate commerce includes the power to regulate the "practices affecting" the "prices at which commodities in that commerce are dealt in. . . ." Wickard v. Filburn, 317 U.S. 111, 128 (1942). Because it directly impacts the prices at which health insurance policies will be sold, individuals' refusal to obtain health insurance is a practice properly subject to regulation by Congress under the Commerce Clause.[9]

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[8] Such Congressional findings are to be considered in the analysis when available, although they are not necessary to sustain the exercise of Commerce Clause authority. Gonzales, 545 U.S. at 21.

[9] United States v. Lopez, 514 U.S. 549 (1995), and United States v. Morrison, 529 U.S. 598 (2000), have no application here as they

The experience in Massachusetts elevates the connection between eliminating free-riders and controlling costs from a rational belief to a demonstrable correlation. Governor Romney and the Massachusetts Legislature, like Congress, determined that an individual health insurance mandate, as part of a comprehensive reform package, would serve to increase access to healthcare while greatly decreasing the detrimental cost-shifting caused by people who chose to forego insurance and shift the cost of their current and future healthcare to others.[10] As discussed above, in the four years after Chapter 58's enactment, there was, indeed, a significant increase in the percentage of insured Massachusetts residents.[11] The significant gains in the number of Massachusetts residents with health insurance helped spur a corresponding sharp decline in the amount of spending on "free care" for the uninsured and under-insured: The amount of free care dropped 33 percent -- hundreds of millions of dollars -- from fiscal year 2006 to fiscal year 2010.[12]

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relate to Congressional attempts to regulate non-economic behavior. See Gonzales, 545 U.S. at 25-26.

[10] Federal law, in fact, requires Medicare-participating hospitals with an emergency department to provide emergency services to stabilize patients with emergency medical conditions regardless of whether they are insured. See 42 U.S.C. § 1395dd (2006).

[11] See Mass. Health Insurance Survey Results, supra note 4.

[12] See Mass. Division of Health Care Finance and Policy, Health Safety Net 2010 Annual Report 4 (Dec. 2010); Mass. Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report 3 (July 2007).

The Massachusetts reform program also has improved healthcare use. From the fall of 2006 to the fall of 2009, more adults (including lower-income adults, adults with chronic health conditions and minority adults) reported visits to doctors and fewer adults reported unmet need for care.[13]

Massachusetts achieved these gains in access to care while making gains in the affordability of care for its residents. In the fall of 2009, as compared with the fall of 2006, and notwithstanding the impacts of the economic recession, there were reductions in both the share of adults reporting high out-of-pocket healthcare spending relative to family income and the share of adults reporting unmet needs for care due to cost.[14] Moreover, according to the most recent information available from the Agency for Healthcare Research and Quality, Massachusetts has slowed the growth trend in health insurance premiums since enactment of healthcare reform in 2006.[15] The rate of premium

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[13] See Blue Cross Blue Shield Found., Health Reform in Massachusetts: An Update as of Fall 2009 10 (June 2010), available at http://bluecrossfoundation.org/~/media/Files/Publications/Policy%20Publications/060810MHRS2009FINAL.pdf [hereinafter BCBS Found. Fall 2009 Update].

[14] Id.

[15] See Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2010 Medical Expenditure Panel Survey-Insurance Component, available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiid1.pdf [hereinafter AHRQ MEPS 2010 Data]; see also Cathy Schoen, Ashley-Kay Fryer, Sara R. Collins, and David C. Radley, The Commonwealth Fund, State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to

growth in Massachusetts since the State enacted health care reform compares favorably to that in many other States, and to the national average. The average cost of employer-sponsored family coverage in Massachusetts as of 2010 was less expensive than in Florida, Illinois, Connecticut, New Hampshire, New York, Rhode Island and Delaware, and within $100 of the annual premium rates in Texas, Wisconsin and Maine.[16]

As the experience with healthcare reform in Massachusetts shows, prohibiting people from opting out of the insurance market when they can afford coverage, and creating incentives for these "free-riders" to join their employer-sponsored health plan or to enroll in a publicly supported healthcare plan, has helped generate "increases in both public and private insurance coverage, and this increase in coverage has translated into increases in the access, use, affordability, and quality of care in the state."[17] Congress could rationally have determined that a similar requirement on the federal level would have the same impact on the interstate market for health insurance.

Address Rising Costs (Nov. 2011), available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Nov/State%20Trends/1561_Schoen_state_trends_premiums_deductibles_2003_2010.pdf [hereinafter Commonwealth Fund Report].

[16] See AHRQ MEPS 2010 Data, supra note 15; see also Commonwealth Fund Report, supra note 15.

[17] BCBS Found. Fall 2009 Update, supra note 13, at 50.

II. THE EXPERIENCE IN MASSACHUSETTS ALSO DEMONSTRATES HOW ELIMINATING FREE-RIDERS IS RATIONALLY RELATED TO SUCCESSFUL IMPLEMENTATION OF OTHER COMPONENTS OF FEDERAL HEALTHCARE LAW; THUS, CONGRESS ALSO HAD AUTHORITY UNDER THE NECESSARY AND PROPER CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT

The Necessary and Proper Clause provided Congress with additional authority to set the minimum coverage requirement as a means to effectuate the broader ends of the ACA. The Constitution gives Congress the power to "make all Laws which shall be necessary and proper in carrying into Execution" its powers, including those under the Commerce Clause. U.S. Const., art. I, § 8, cl. 18.

As with the analysis under the Commerce Clause, the standard for determining whether legislation is authorized under the Necessary and Proper Clause is a relaxed one. Enactment of a particular federal law is authorized by the Necessary and Proper Clause when "the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." United States v. Comstock, ___ U.S. ___, 130 S.Ct. 1949, 1956 (2010). In Comstock, the Court reiterated its nearly 200-year-old formulation of this authority, that the Necessary and Proper Clause is a "broad power to enact laws that are 'convenient, or useful' or 'conducive' to the . . . 'beneficial exercise'" of specifically granted powers. 130 S.Ct. at 1956 (quoting McCulloch v. Maryland, 4 Wheat 316, 413, 418 (1819)).

Thus, even if Congress lacked authority under the Commerce Clause to impose the minimum coverage requirement -– which it did not; see Argument I, supra –- it was authorized by the Necessary and Proper Clause to impose the requirement as a rational requisite of implementing other components of federal law that were unequivocally permitted by the Commerce Clause. Congress made particular findings that make clear the rational relationship between the minimum coverage requirement and Congress's exercise of its Commerce Clause powers in other related legislation. First, Congress found that:

> Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and [the ACA], the Federal Government has a significant role in regulating health insurance. The [minimum purchase] requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

ACA § 1501(a)(2)(H), as amended by § 10106.

Second, Congress, in § 1201 of the ACA, makes changes to the Public Health Service Act that ban pre-existing condition exclusions and discrimination in health insurance based on health status. Congress found that:

> Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health

> insurance until they needed care. By significantly increasing health insurance coverage, the [minimum coverage] requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold.

ACA § 1501(a)(2)(I), as amended by § 10106.

Massachusetts's experience gives additional support to the conclusion that the minimum coverage requirement was, at a minimum, rationally related to the implementation of Congress's unquestioned authority under the Commerce Clause to alter other aspects of the federal healthcare regulatory landscape. Specifically, as discussed above, Massachusetts utilized just such a provision as a linchpin of its comprehensive reform and has reaped intrastate benefits through sharp reductions in spending on "free care" for uninsured residents and improved access to healthcare.

III. FEDERAL REFORM IS NECESSARY TO ADDRESS SIGNIFICANT INTERSTATE ASPECTS OF HEALTH CARE WHICH ARE BEYOND THE SCOPE OF INDIVIDUAL STATE AUTHORITY

There remains a limit to the structural changes Massachusetts -- or any other State attempting to "go it alone" -- can effect in the healthcare marketplace. A single State's freedom of action is necessarily constrained by jurisdictional limits and the pre-emptive overlay of federal law. Even successful healthcare innovations on the State level have impacts beyond State borders. During fiscal year 2009 alone, for example, Massachusetts hospitals provided inpatient care to more than 43,000 patients who were not residents of Massachusetts, at an estimated cost of $910,000,000.[18] Of these non-Massachusetts residents, approximately 1,200 did not have any health insurance.[19] The number of out-of-state patients without insurance coverage was even greater at Massachusetts emergency departments where more than 12,900 uninsured individuals received care during fiscal year 2009.[20] Massachusetts cannot regulate insurance coverage for non-Massachusetts residents, nor can it (or should it) restrict access to necessary and emergent care. This interstate flow of patients (including uninsured patients) is but one

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[18] Mass. Division of Health Care Finance and Policy, Hospital Discharge Database (HDD) for fiscal year 2009 (October 1, 2008 through September 30, 2009).

[19] Id.

[20] Id.

illustration that individual states cannot effectively account for, let alone mitigate, the impact of healthcare trends felt on the national and interstate levels.

Congress has long recognized that employer health plans had "operational scope and economic impact" that was "increasingly interstate."[21] The federal government already exercises significant control over a large section of the private group health plan market. In Massachusetts, more than half of this market is made up of self-insured plans that, because of ERISA's preemptive effect, are beyond the direct reach of state regulators.[22]

Nationwide, the number of people enrolled in these self-insured employer plans has increased markedly since 1999. In 2007, 55 percent of the 132.8 million people in plans governed by ERISA were in self-insured plans, up from 44 percent in 1999.[23] The federal government has long exercised exclusive regulatory authority over these self-insured employer benefit plans. The continued growth of self-insured plans, coupled with the interstate nature of the

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[21] ERISA, Pub. L. No. 93-406, § 2.

[22] The "private group market" includes large group, small group, and self-insured members. See Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, 4, 6 (Nov. 2010), available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_november_2010.pdf.

[23] See William Pierron & Paul Fronstin, ERISA Pre-emption: Implications for Health Reform and Coverage, 314 EBRI Issue Brief 11 (Feb. 2008), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

healthcare marketplace, demonstrates the need for the federal reforms contained in the ACA to establish minimum national standards for health coverage. Nothing in the ACA constrains individual States from further regulating intrastate aspects of the health insurance market – as Massachusetts has done in Chapter 58 -- if they so choose.

Massachusetts has already experienced the economic benefits of tackling the free-rider problem head-on, by enacting comprehensive reforms that include a requirement that individuals who can afford health insurance must purchase it. Massachusetts has substantially increased the numbers of insured and substantially decreased "free care" costs. The experience in Massachusetts shows that, when Congress included a similar minimum coverage requirement in the ACA, it acted pursuant to its enumerated powers under Article I to promote – for the Nation – more affordable and accessible healthcare.

CONCLUSION

For these reasons, Massachusetts urges the Court to hold that Article I conferred upon Congress the requisite authority to enact the Patient Protection and Affordable Care Act.

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