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.,

Respondents.

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

BRIEF OF HEALTH CARE FOR ALL, INC., HEALTH LAW ADVOCATES, INC., THE MASSACHUSETTS HOSPITAL ASSOCIATION, INC., THE MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS, INC., GREATER BOSTON INTERFAITH ORGANIZATION, INC., AND COMMUNITY CATALYST, INC. AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS URGING REVERSAL ON THE MINIMUM COVERAGE PROVISION ISSUE

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QUESTION PRESENTED

Massachusetts's experience with health reform demonstrates that health care and health insurance are inherently interstate activities that cannot be successfully regulated without federal involvement.

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

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INTERESTS OF *AMICI CURIAE*[1]

Health Care For All, Inc. (HCFA) was a key advocate for the enactment of the 2006 Massachusetts state health reform law and has been extensively involved with many aspects of the implementation of health care reform in Massachusetts. Health Care For All empowers Massachusetts consumers to learn more about the State's health care system, and to become involved in changing it. Health Care For All provides services enabling Massachusetts consumers, particularly the vulnerable members of society, to connect with necessary health resources. The organization uses policy analysis, personal and legal advocacy, community organizing and public education to achieve the goal of creating a consumer-centered health care system that provides comprehensive, affordable, accessible, culturally competent, high quality and consumer driven care to everyone, particularly the most vulnerable. HCFA also has research and legislative staff that work to advance state law in the best interest of consumers. HCFA has established and organized The Affordable Care Today (ACT!!) Coalition, which is a group of seventy-five organizations including community and religious organizations, labor

[1] This brief is submitted with the consent of the parties, as lodged with the Clerk per the Docket Sheets. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party. All expenses of *amici* have been borne by their own resources and by *pro bono* support from the Health Law Program at Boston University School of Law, without support from any party.

unions, doctors, hospitals, community health centers, public health advocates, and consumers who are committed to implementing the Massachusetts comprehensive health care reform act.

Health Law Advocates, Inc. is a public interest law firm whose mission is to provide *pro bono* legal representation to Massachusetts residents experiencing difficulty accessing or paying for needed medical care. This litigation experience gives Health Law Advocates a unique perspective on the need for adequate health insurance and related issues with health reform in Massachusetts. Health Law Advocates is committed to ensuring universal access to quality health care in Massachusetts, particularly for those who are most at risk due to race, national origin, alienage, gender, disability, age or geographic factors. Health Law Advocates combines legal expertise with grassroots organizing to advance the statewide movement for universal health care access.

The Massachusetts Hospital Association, Inc. (MHA) is a voluntary, not-for-profit organization comprised of hospitals and health systems, related organizations, and other members with a common interest in promoting the good health of the people of the Commonwealth. Through leadership in public advocacy, education, and information, MHA represents and advocates for the collective interests of its members and supports their efforts to provide high quality, cost effective and accessible care.

The Massachusetts League of Community Health Centers, Inc. is the state's primary care association, and as such, represents and serves the needs of Massachusetts's fifty community health center organizations. The League's work includes state and federal health policy analysis, providing training and education for health center staff and boards of directors, and working with local advocacy organizations to create and support health centers in their communities in order to expand access to healthcare.

Greater Boston Interfaith Organization, Inc. works to organize the Greater Boston community for the public good, by developing local leadership and fighting for social justice. Currently, the Greater Boston Interfaith Organization's health care initiative focuses on ensuring that Massachusetts's most vulnerable residents do not bear the burden of paying for health care reform, and encouraging State leaders to remain committed to funding health reform.

Community Catalyst, Inc. is a national nonprofit consumer advocacy organization which is dedicated to quality and affordable health care for all. Community Catalyst is located in Boston, Massachusetts, and works in partnership with national, state and local organizations, policymakers, and foundations, providing leadership and support to improve the health of communities and to change the health care system so that it serves everyone.

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SUMMARY OF ARGUMENT

In 2006 the Commonwealth of Massachusetts, with the support of the federal government, implemented a health reform law requiring Massachusetts residents to maintain affordable and comprehensive health insurance. The Commonwealth's experience provides an important context for assessing the constitutionality of the minimum coverage provision in the Patient Protection and Affordable Care Act (the Act).

Health reform efforts in Massachusetts have been very effective in expanding insurance coverage within the State, but only with substantial federal support through a Medicaid demonstration waiver.

The Commonwealth's experience also illustrates that the health insurance and health care markets are inherently interstate commerce. Decisions by out-of-state residents to forgo insurance, the very decisions subject to the Act's minimum coverage provision, have imposed substantial externalities on the Commonwealth's health care system. Each year, out-of-state residents continue to seek and receive millions of dollars in uncompensated care in Massachusetts hospitals, limiting the State's efforts to improve its health care system through the elimination of uncompensated care. These externalities directly affect Massachusetts health care providers, and indirectly, Massachusetts taxpayers and premium payers. In addition, the federal Employee Retirement Income Security Act (ERISA) limits the Commonwealth's ability to

regulate employer-sponsored health plans. Each of these issues results in gaps in health care reform that Massachusetts cannot fill with its own laws, creating barriers to achieving the full magnitude of health care reform for its residents.

These barriers to state reform are not unique to Massachusetts. Any state seeking to reform its health care and health insurance systems will face similar issues. States cannot solve these problems entirely on their own. As such, the federal government must have the power to help address these problems; otherwise, one state's desire to create workable health care reform would be held captive to the decisions made by out-of-state individuals and surrounding states. The Commerce Clause was designed to remedy just such problems.

ARGUMENT

I. Massachusetts health care reform was the model for the Patient Protection and Affordable Care Act and has been remarkably effective in increasing insurance coverage and improving access to care.

In 2006, former Governor Mitt Romney signed into law An Act Providing Access to Affordable, Quality, Accountable Health Care (Chapter 58). Ch. 58, 2006 Mass. Acts 77. Chapter 58 has been largely successful in reducing the number of uninsured individuals, thereby reducing the costs associated with providing

uncompensated "free" care and creating more representative and better balanced insurance risk pools. The experience of Massachusetts, however, illustrates the need for federal involvement to accommodate the interstate nature of the health care and health insurance markets. The states cannot solve the problems facing their health care systems alone and must rely on the federal government's authority to do so.

The Patient Protection and Affordable Care Act (the Act), Pub. L. No. 111-148, 124 Stat. 119, mirrors many of the provisions present in the Massachusetts health reform effort. For example, both reforms regulate the individual and small group markets and establish insurance exchanges in which consumers can compare and access insurance plans. Compare 42 U.S.C.A. 18031 with Mass. Gen. Laws ch. 176Q. In addition, both Massachusetts and federal reform efforts include provisions imposing a financial penalty if individuals fail to maintain adequate health insurance. Compare 26 U.S.C.A. 5000A (the minimum coverage provision penalty) with Mass. Gen. Laws ch. 111M, § 1 (defining qualifying credible coverage). Massachusetts thus imposes a minimum coverage provision on its residents quite similar to the Act's minimum coverage provision.

In order to ensure affordable access to care, Chapter 58 utilizes several strategies, in addition to the minimum coverage provision, that were subsequently paralleled in the Act. For example, Chapter 58 expands MassHealth (the State's Medicaid program), Mass. Gen. Laws ch. 118E, § 9A; encourages

employers to provide health insurance to their employees, Mass. Gen. Laws ch. 118G, § 18B; and through the Commonwealth Care program, provides sliding scale premium subsidies to residents with incomes up to 300 percent of the federal poverty level (FPL), pursuant to Mass. Gen. Laws ch. 118H, § 2.

These expansions of coverage were made possible in part because the federal Department of Health and Human Services approved, pursuant to 42 U.S.C. 1115, a Medicaid demonstration waiver permitting the State to expand MassHealth eligibility and receive significant federal financial support for the implementation of its health care reform. Centers for Medicare & Medicaid Servs., *Section 1115 Medicaid Demonstration Fact Sheet* 1-2 (Dec. 14, 2011) (*Section 1115 Fact Sheet*).

The federal Medicaid waiver, a key source of funding for the 2006 reform, expired on June 30, 2011, and was reapproved on December 21, 2011, after nearly a year and a half of negotiations between the State and federal government. Chelsea Conaboy, *US Extends State's Medicaid Waiver: Deal Changes How Some Hospitals are Paid*, Bos. Globe, Dec. 20, 2011, at B1; *Section 1115 Fact Sheet* 1. If the federal waiver and the additional funds thereunder had not been renewed, Massachusetts might have been unable to sustain Chapter 58's insurance coverage expansion efforts.

Massachusetts further financed Chapter 58's expanded access to insurance by replacing the

Uncompensated Care Pool, through which the State had paid hospitals for care for eligible uninsured residents and provided health care to residents and nonresidents, with a modified program called the Health Safety Net. Leighton Ku et al., Kaiser Comm'n on Medicaid & the Uninsured, *How Is the Primary Care Safety Net Faring in Massachusetts?: Community Health Centers in the Midst of Health Reform* 7 (Mar. 2009). In enacting Chapter 58, the legislature decided that the State's resources would be better utilized by providing residents with insurance so that they could receive appropriate medical care in outpatient settings, rather than by incurring the costs of uninsured patients in hospitals. See Office of Medicaid, Mass. Exec. Office of Health & Human Servs., *Section 1115 Waiver Amendment Proposal* 7 (May 1, 2006) (stating that the funding for the State's Health Safety Net reimbursement program will decrease proportionally with the increase in funding for insurance premium assistance).

The reforms established by Chapter 58 have successfully reduced the number of uninsured individuals and expanded access to care. In 2004, prior to Chapter 58, 7.4% of Massachusetts residents were uninsured. Amy M. Lischko, Mass. Exec. Office of Health & Human Servs., *Health Insurance Status of Massachusetts Residents Report, Fifth Edition: December 2006*, at 3 tbl.1 (2006). By 2010, four years after Chapter 58 was passed, the uninsured population had dropped to just 1.9%. Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs.,

Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys 8 (Dec. 2010) (*Health Insurance Surveys*). Overall, insurance access was expanded to 411,722 Massachusetts residents. Div. of Health Care Fin. & Policy, Exec. Office of Health & Human Servs., *Health Care in Massachusetts: Key Indicators* 3 (May 2011) (*Key Indicators*). Insurance coverage gains in Massachusetts were particularly significant among population groups most likely to lack health insurance, including Hispanic individuals and persons below 150% FPL. See *id.* at 13-14.

Significant decreases in the uninsurance rate among Massachusetts residents are in stark contrast to the national uninsurance rate, which increased from 14.9% in 2004 to 16.3% in 2010, Blue Cross Found., *Assessing the Results* 9 (Oct. 2011) (*Assessing the Results*), reaching 21.3% in Florida and 23.7% in Texas as of 2010, U.S. Census Bureau, *Percent Without Health Insurance Coverage – United States – States; and Puerto Rico* (*U.S. Census Uninsured*). The number of uninsured nonelderly adults increased in all forty-nine other states between 2007 and 2009. Center for American Progress, *Dramatic Increase in Uninsured Rate in Every State* (May 2009).

Researchers have credited the Massachusetts minimum coverage provision with helping to increase the Commonwealth's rate of insurance as well as improving the actuarial balance of the State's risk pools. See, e.g., Amitabh Chandra et al., Perspective, *The Importance of the Individual Mandate – Evidence*

from Massachusetts, 364 New Eng. J. Med. 293, 295 (2011). States seek to improve the balance or mix of patients in their risk pools so that the costs of health care can be spread over a broader group of individuals; this helps to maintain the affordability of premiums. *Id.* at 293. The same researchers also noted a large increase in enrollment in Massachusetts health plans by healthy individuals immediately after the minimum coverage provision went into effect, suggesting that the law directly improved the actuarial balance in the State's risk pools. *Id.* at 295 (showing that enrollment increased, including enrollment by healthy individuals in Commonwealth Care increased from about 2,500 in November 2007 to 6,000 in December 2007).

Chapter 58 also improved the access to medical care enjoyed by Massachusetts residents and reduced the number of residents with inadequate health insurance. Underinsurance arises when individuals have cost sharing which is commonly typified by high out-of-pocket expenses as a result of unaffordable deductibles or co-payments, or significant limitations on coverage, such as annual or lifetime limits and excluded conditions. Jenny Gold, *The 'Underinsurance' Problem Explained*, Kaiser Health News, Sept. 28, 2011; see also Lorianne Sainsbury-Wong & Elizabeth G. Ryland, *Protecting Consumers: The Elimination of Lifetime and Annual Limits on Health Insurance Benefits*, Mass. Bar Ass'n Law. J. (June 2011) (showing that despite robust reform in Massachusetts, residents would benefit from the additional protections of the

Act with respect to lifetime and annual limits). The Massachusetts reform reduced the overall population of non-elderly adults who suffered high out-of-pocket health costs. Blue Cross Found., *supra* at 24 (explaining that between 2006 and 2009, the percentage of adults reporting out-of-pocket costs in excess of 10% of family income decreased from 10% to 4%). The number of uninsured and insured adults reporting that cost posed an obstacle to needed care declined from 79% and 32%, respectively, to 66% and 28%, respectively. *Key Indicators* at 15. In 2009, 78% of Massachusetts residents reported having a preventive care visit within the year, an increase from 71% prior to the reform. Blue Cross Found., *supra* at 28. All of this was achieved during a period when the national rate of people lacking health insurance continued to rise. *Assessing the Results* at 9.

In short, the Massachusetts model for federal health reform has been remarkably effective, but success required both the minimum coverage provision and a strong state-federal partnership.

II. Health care and health insurance markets constitute interstate commerce and are affected by the decisions of out-of-state residents to forgo insurance.

A. Out-of-state residents regularly seek cross-border care in Massachusetts.

Massachusetts's experience with health reform underscores the interstate nature of both the health

care and the health insurance markets. Although Massachusetts successfully implemented Chapter 58, that reform depended in part upon federal action: federal financial support for Massachusetts health reform includes the award of the Section 1115 demonstration waiver, which authorized the expansion of MassHealth and related reform initiatives such as the Commonwealth Care program, which is a sliding scale state-subsidized insurance program established under Mass. Gen. Laws chs. 118H and 176Q. Even with strong federal support and its own comprehensive reform, the Massachusetts health system continues to be affected by the decisions of uninsured and underinsured people from other states who seek care in Massachusetts but remain outside the scope of many of the Commonwealth's reform laws, including its minimum coverage provision. Although individual states can implement broad health care reforms pursuant to their traditional state police powers, a state may not "limit to its own residents the general medical care available within its borders." *Doe v. Bolton*, 410 U.S. 179, 200 (1973) (holding that the Privileges and Immunities Clause protects non-residents seeking medical care within another state).

Patient traffic is never entirely contained within the borders of an individual state. Indeed, for many years the Centers for Medicare and Medicaid Services (CMS) published a metric, the net-flow ratio, to measure the net flow of patients across state borders for the purpose of using health care providers. See Anne B. Martin et al., Trends, *Health Spending by State of*

Residence, 1991-2004, 26 Health Affairs w651, w658 (2007) (web exclusive) (including a copy of the government's most recent net-flow table in Exhibit 5). The New England region, as a whole, is a net exporter of health care services, meaning that it provides more services than its own population consumes. *Id.* at w659, exh. 5. New England's status as a net exporter is caused in no small part by Massachusetts's production of more health care services than its residents use. Of the six states in New England, only Massachusetts and Rhode Island are net exporters of health care services. *Id.*

Massachusetts serves as a destination for inbound patients from many other states, including people seeking care at several prestigious Massachusetts hospitals. For example, in 2004, the last year CMS published net-flow ratios, Massachusetts had the ninth-lowest ratio in the nation, whereas neighboring Vermont had the fifth-highest ratio. *Id.* Inpatient hospital discharge data published by the Vermont Department of Banking, Insurance, Securities, and Health Care Administration indicates that, in 2008, Massachusetts hospitals discharged 1,034 Vermont residents from inpatient care. Dept. of Banking, Ins., Secs., & Health Care Admin., *Vermont Hospital Migration Report* 13 (Mar. 2010). During that same period, Vermont hospitals discharged 211 inpatient patients from Massachusetts, only one-fifth as many. *Id.* In addition, Vermont inpatients discharged from Massachusetts hospitals had three times the average charge per visit as Vermont inpatients discharged

from Vermont hospitals. *Id.* at 15. In short, many higher-cost out-of-state patients come to Massachusetts for care and Massachusetts cannot require that they first comply with the health insurance coverage provisions under Chapter 58. See Mass. Gen. Laws ch. 111M, § 2 (applying the minimum coverage provision to "residents" and individuals who become residents "within 63 days").

Out-of-state patients from neighboring states constitute a sizeable portion of the patient flow for many Massachusetts hospitals and other health care providers. Twenty-three Massachusetts hospitals are located within ten miles of an interstate border. See Div. of Health Care Fin. & Policy, *Statewide Map of Massachusetts Hospitals*, Mass. Exec. Office of Health & Human Servs. (2011) (*Statewide Map*) (*amici* used GoogleMap software in conjunction with the hospital addresses to calculate the distances between hospitals and state borders). Some health care providers near the Massachusetts border hold themselves out as the main provider for residents just across the state line. For example, the website for the Steward Holy Family Hospital, located in Methuen, Massachusetts, characterizes the provider as "serv[ing] some 450,000 individuals and their families in 20 communities throughout the Merrimack Valley *and southern New Hampshire*" (emphasis added). *Holy Family Hospital*, Steward Health Care System. Hospital summary utilization data compiled by Massachusetts's Executive Office of Health and Human Services demonstrate how large a portion of a border hospital's total

patient population out-of-state patients are. See Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Hospital Summary Utilization Data* (2011). Every year, the Office publishes the most frequent 40 zip codes of patient origin for Massachusetts hospitals, indicating what percentage of the hospitals' total patient populations each zip code represents. Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Top 40 Zip Codes (HSD09)* (2011) (*Top 40 Inpatient*); Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Outpatient Observation Top 40 Zip Codes (HSD18)* (2011) (*Top 40 Outpatient*); Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Emergency Department Top 40 Zip Codes (HSD23)* (2011) (*Top 40 ED*). Analysis of these data collections demonstrates that hospitals near the state border have a high percentage of patients coming from outside the state boundaries.[2] For instance, for Steward Holy Family Hospital, mentioned *supra*, approximately 17% of its inpatient visits, see *Top 40 Inpatient*, 21% of its outpatient visits, see *Top 40 Outpatient*, and 12% of its emergency department visits, see *Top 40 ED*, originated outside of

[2] The approximate proportion of visits by out-of-state residents may be determined by selecting all visits by a particular hospital in "column A," eliminating Massachusetts zip codes in "column E," and then calculating the sum of "column G." See also Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Field Description Listing by File (HSD24)* (2011) (providing definitions of field terms for each data set).

Massachusetts in 2010. Two other hospitals located near the Massachusetts border that provide care to a high percentage of out-of-state patients are Fairview Hospital and Steward Saint Anne's Hospital. Both hospitals reported that approximately 12% of inpatient visits and 11% of outpatient visits were by patients from outside Massachusetts in 2010. See *Top 40 Inpatient*, and *Top 40 Outpatient*.

B. Due to New England's integrated economy, out-of-state commuters make up a significant portion of the Massachusetts workforce and obtain health services in Massachusetts.

The Massachusetts health care market is further exposed to out-of-state externalities through its regionally integrated labor force.[3] As of 2000, out-of-state residents commuting into Massachusetts for work constituted 5.5% of the entire Massachusetts

[3] Under Chapter 58, the Massachusetts minimum coverage provision applies to any individual who files a Massachusetts resident income tax return. Mass. Gen. Laws ch. 111M, § 2 (limiting the minimum coverage provision to "residents" and individuals who become residents "within 63 days"). Residents are primarily defined as individuals filing resident income tax returns in Massachusetts. *Id.* at §1. Even though nonresidents whose Massachusetts gross income exceeds $8,000 per year are required to file a nonresident income tax return, they are not subject to the minimum coverage provision. See Mass. Gen. Laws ch. 111M, § 1; Mass. Dept. of Revenue, *Who Must File* (2011).

workforce. Mass. Inst. for a New Commonwealth, *Mass.commuting* 29 (Oct. 2004) (*Mass.commuting*). Of the 176,741 out-of-state residents commuting into Massachusetts, 81,490, or 46.1%, were from New Hampshire. *Id.* These factors are particularly significant in Rockingham County, New Hampshire, where nearly one-third of the county's 148,703 employed residents commute to Massachusetts for work. Econ. & Labor Mkt. Info. Bureau, N.H. Emp't Sec., *Rockingham County Commuting Patterns* 1 (2004). Similar situations exist near the Massachusetts borders with other states such as Rhode Island, and, to a lesser extent, Maine, Vermont, Connecticut and New York. See *Mass.commuting* 30. These interstate labor markets, which may have many other economic advantages, create difficulties for an individual state which seeks to manage its health care and health insurance markets.

C. Each year Massachusetts hosts millions of tourists and business visitors who may require emergency or other health care services during their visit.

The Massachusetts health care system is further affected by the need to provide for the health care of the significant number of people who visit Massachusetts each year from across the country and indeed around the world. According to the Massachusetts Office of Travel and Tourism, approximately 16.7 million out-of-state residents visit Massachusetts each year for recreational activities, leisure, and business

trips, among other reasons. Mass. Office of Travel & Tourism, *2010 Annual Report* 10 (2010). Tourists are drawn to historic and cultural features such as Boston's revolutionary-era landmarks and to natural landscapes such as the beaches of Cape Cod and the Islands. Business visitors are also attracted to the State; indeed, Boston ranks as one of the nation's top destinations for business travelers. *Top 10 U.S. Business Destinations*, CNN Travel (Sept. 11, 2007). In addition, many out-of-state residents own vacation homes in Massachusetts. As of 2000, 3.6% of all Massachusetts homes were for "seasonal, recreational, or occasional use." Hous. & Household Econ. Statistics Div., U.S. Census Bureau, *Historical Census of Housing Tables: Vacation Homes* (last revised Oct. 31, 2011). Many of these homes were owned or rented by residents of neighboring states. Lisa Selin Davis, *Still Alternative After All These Years*, N.Y. Times, Jan. 22, 2009, at D3 (quoting a realtor stating that in Leverett, Massachusetts, many "second-home owners come from New York City").

The skiing industry figures prominently in the tourism economies of Vermont and New Hampshire, but also to an extent in Massachusetts. Because skiing is an activity with inherent safety risks, see Hulyun Xiang et al., *Skiing- and Snowboarding-Related Injuries Treated in U.S. Emergency Departments, 2002*, 58 J. Trauma 112, 113 (2005) (study finding that 139,300 skiers and snowboarders nationwide received treatment in hospital emergency rooms during 2002), and is often performed in relatively

rural environments, it is unsurprising that hospitals are located in close proximity to major ski areas in Massachusetts. Compare *Statewide Map* with *Massachusetts Ski Resort and Ski Area Locator Map*, AlpineZone.com.

The rural town of Great Barrington, Massachusetts, with 7,104 residents, U.S. Census Bureau, *Interactive Population Map* (follow "Total Population"; then follow "County Subdivision"; then search "Great Barrington, MA"), illustrates the impact that tourists and out-of-state second home owners can have on the health care services in many Massachusetts communities. Great Barrington and its surrounding communities are served by Fairview Hospital which is situated within eight miles of both Butternut and Catamount Ski areas and within twelve miles of the Connecticut and New York borders. *Id.* Because of these characteristics, Fairview Hospital's emergency department case mix reflects above-average numbers of visits by out-of-state patients, for medical issues relating to accidents and physical injuries, who lack public or private insurance. In 2010, 1,279 emergency room patients at Fairview Hospital were out-of-state residents, a figure comprising 10.89% of total emergency room visits at the hospital. *Top 40 ED* (calculating sum of "column F" and "column G," respectively, for visits to Fairview Hospital by non-Massachusetts zip codes). The clinical classifications (CCS) of these visits to Fairview Hospital were disproportionately related to fractured limbs and contusions, as compared with statewide hospital emergency room averages.

Compare Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Emergency Department Top 20 Clinical Classifications Software by Hospital (HSD22)* (2011) with Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Emergency Department Clinical Classifications Software Information (HSD19)* (2011) (contrasting Fairview Hospital's percentage of emergency visits with statewide averages for upper limb fracture, 2.82% to 1.73%, lower limb fracture, 1.44% to 0.88%, and contusion, 10.42% to 5.78%). Moreover, 7% of emergency room patients at Fairview attempt to finance their visit through "self-pay" methods due to lack of private or public coverage. See Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *403 Payer Utilization (HSD11)* (2011) (*Payer Utilization*) (after dividing total overall emergency visits in "column BO" by total emergency self-pay visits in "column BU," the proportion of self-pay ED visits is found; the results indicate that only six other hospitals in Massachusetts had a higher proportion of self-pay ED visits than Fairview). Statewide, six of the ten hospitals with the highest rate of emergency room patients lacking insurance were located within a ten-mile radius of an interstate border. *Id*.

D. Federal law forbids most hospitals from discriminating based on residency and insurance status when providing emergency medical services.

Massachusetts hospitals frequently provide emergency care to uninsured, or underinsured, out-of-state patients. See Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *403 Payer Utilization (HSD11)* (2011) (*Payer Utilization*) (demonstrating that Massachusetts hospitals with above-average out-of-state patient populations tend to have higher numbers of "self-pay" patients). The federal Emergency Medical Treatment and Active Labor Act (EMTALA) prohibits a hospital participating in Medicare from refusing emergency treatment to a patient due to residency, insurance, or other listed categories. EMTALA, 42 U.S.C. 1395dd; *Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 252 (1999) (holding that all Medicare participating hospitals cannot discriminate against patients based on their ability to pay when providing emergency services). Because EMTALA ensures access to emergency medical treatment, participating Massachusetts hospitals must conduct medical screenings and examinations, including ancillary services routinely available at the emergency room, for any person, including an out-of-state resident, who presents with an emergency medical condition. *Id*. at 1395dd(a). Whenever such an emergency condition exists, Massachusetts hospitals must stabilize the condition or transfer the patient to another facility with appropriate services. *Id.* at 1395dd(b)(1). Many

specialized Massachusetts hospitals, such as Children's Hospital Boston or the Massachusetts Eye and Ear Infirmary, *Best Hospitals in Boston, MA*, U.S. News Health, must accept medically needed transfers in situations where they are the only providers who can adequately care for a specific emergency condition. *Id.* at 1395dd(g). EMTALA preempts state laws that conflict with EMTALA's mandated emergency treatment requirements for eligible hospitals. *Id.* at 1395dd(f).

Even without EMTALA, most Massachusetts hospitals would have to provide emergency care to non-residents. Mass. Gen. Laws ch. 111, § 70E (granting patients the right to emergency treatment without discrimination based on the ability to pay). In addition, denying emergency care to non-residents would run counter to the key mission of charitable health providers and would raise federal tax exemption issues for non-profit hospitals. Rev. Rul. 56-185, 1956-1 C.B. 202, *modified by* Rev. Rul. 69-546, 1969-2 C.B. 117 (holding that charitable hospitals exempt from federal income taxation "must not, however, refuse to accept patients in need of hospital care who cannot pay for such services."). Hospitals also cannot easily refuse to treat non-emergency patients from outside the Commonwealth because discrimination against out-of-state residents may well be unconstitutional. See *Doe v. Bolton*, *supra* at 200.

The impact on the Commonwealth and Massachusetts hospitals regarding their obligation to treat non-residents in their emergency rooms is not trivial.

At least 38,937 out-of-state residents made an emergency visit to a Massachusetts hospital in 2010, of which over 35,227 were out-of-state residents from other New England states. *Top 40 ED* (calculating the sum of total statewide visits in "column I" for each non-Massachusetts zip code). Assuming just one emergency visit per non-resident and that their visits resulted in the average cost of an emergency room visit, out-of-state residents used about 19.9 million dollars' worth of health care services for emergency room visits alone. See Div. of Health Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs., *Preventable/ Avoidable Emergency Department Use in Massachusetts: Fiscal Years 2004 to 2008*, at 11 (2010) (finding that the average cost for an emergent ED visit was $510).

While the Massachusetts health reforms resulted in a decrease in uninsured state residents from 7.4% to 1.9% between 2006 and 2010, the rates of uninsurance in bordering states have increased or remained largely static during the same time period. See U.S. Census Bureau, *Health Insurance Historical Tables* (Nov. 8, 2011) (rates of uninsurance in Connecticut: 10.9% in 2004, 9.1% in 2010; in Maine: 8.9% in 2004, 10.1% in 2010; in New Hampshire: 10.1% in 2004, 11.1% in 2010; in Vermont: 10.5% in 2004, 8.0% in 2010). By themselves, residents of Salem, New Hampshire, accounted for over 7% of all emergency visits to Steward Holy Family Hospital in Methuen, Massachusetts. *Top 40 ED*; see *supra* note 2. Eleven percent of residents of Rockingham County, New

Hampshire, in which Salem is located, lack health insurance, a much higher percentage than the Massachusetts uninsurance rate. U.S. Census Bureau, *Small Area Health Insurance Estimates* (Oct. 2011).

E. The burden of in-state health care for uninsured or underinsured out-of-state residents falls on Massachusetts.

Chapter 58 attempted to finance the expansion of health insurance and improve the affordability and quality of health care in the State by reducing reliance on expensive, uncompensated emergency room care in favor of insured, appropriate, out-patient care. In particular, the State anticipated that with the expansion of health insurance, it could achieve dramatic reductions in uncompensated care, resulting in savings that could be used to expand insurance coverage. Post-reform experience, however, has demonstrated that due, in part, to the State's inability to impose its minimum coverage provision on out-of-state residents, Massachusetts taxpayers and premium payers still incur costs as uninsured patients continue to seek and receive health care in the State. See Jon Kingsdale, *Implementing Health Reform in Massachusetts: Strategic Lessons Learned*, 28 Health Affairs w588, w589-90 (2009) (web exclusive). This is not a problem that the State can solve readily, as any attempt to apply the Massachusetts minimum coverage provision on residents of other states could run afoul of limitations under the Commerce Clause. See

Kevin Outterson, *Health Care, Technology and Federalism*, 103 W. Va. L. Rev. 504, 515-21 (2001).

In Massachusetts, the reimbursement of medically necessary services consumed by uninsured or underinsured residents is regulated by the Commonwealth's Health Safety Net Care Pool (HSN), the successor to a program established in 1985 to help compensate providers for care given to individuals without adequate health insurance or ability to pay. *Second Report to the House and Senate Committees on Ways and Means* 5 (Nov. 2005). Prior to 2006, out-of-state patients were eligible to receive certain medically necessary services based on a showing of financial hardship. *Id.* at 49. For example, in fiscal year 2004, reimbursement on behalf of uninsured out-of-state patients cost the State $36.95 million. *Id.* at 60. As part of the Chapter 58 health care reform effort, however, the State reduced its support for uncompensated care, seeking to redirect its resources toward enabling its residents to obtain and maintain affordable and comprehensive insurance. Leighton Ku et al., *supra* at 7-8. To help pay for the reduction, the State denies benefits under HSN to out-of-state residents. Mass. Gen. Laws ch. 118G, § 39(a)(1) ("Reimbursements for health services provided to residents of other states and foreign countries shall be prohibited.")

When the Commonwealth does not pay for inadequately insured out-of-state residents, the bad debt burden continues to fall on Massachusetts providers such as physicians, community health centers, and hospitals. As noted above, hospitals cannot avoid the

costs associated with uninsured out-of-state patients by merely refusing to provide emergency care. See, e.g., EMTALA, 42 U.S.C. 1395dd. Indeed, *amici* strongly advocate for access to medically necessary care regardless of one's state of residence. However, the costs of care provided to out-of-state uninsured patients are passed along to the residents of Massachusetts, either through their taxes or through the premiums and cost-sharing they pay when attaining the coverage required by the State. John Holahan & Stan Dorn, Robert Wood Johnson Found., *What is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States?* 2 (June 2010) (finding that state spending on uncompensated care, and state-funded health care programs, is substantial, and that states spent 17.2 billion on the uninsured in 2008). As a result, the State's ability to reform its health care market, control hospital costs, and provide affordable care to nearly all of its residents is limited by its inability to regulate the decisions of out-of-state residents to forgo health insurance. Only Congress, which has the sole power to regulate interstate commerce, can address this problem, as it did when it enacted the Act and imposed a national minimum coverage provision.

III. Due to ERISA, Massachusetts has a limited ability to regulate certain employer-sponsored group health insurance plans.

States such as Massachusetts that attempt to achieve universal health care also face constraints in

their ability to regulate the health insurance of their own residents due to the Employee Retirement Income and Security Act of 1974 (ERISA), which regulates employer-sponsored benefit plans, including group health insurance plans. 29 U.S.C. 1101; *Shaw v. Delta Air Lines*, 463 U.S. 85, 90 (1983). ERISA was enacted by Congress in part to "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 142 (1990). To free employers from that burden, ERISA includes a broad preemption provision that prevents many state regulations of employer-sponsored group health plans. 29 U.S.C. 1144. In addition, although ERISA "saves" state laws that regulate insurance, ERISA makes clear that self-funded plans are wholly exempt from state insurance laws. *Id.* at 1144(b)(2)(b). ERISA also blocks state common law remedies for improper denials of health insurance coverage. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004). Indeed, ERISA establishes an exclusive federal remedy for claims against employer-sponsored plans. *Id.* at 218; 29 U.S.C. 1132(a).

ERISA's impact on a state's ability to reform its own health insurance market is significant. In the United States, 55.3% of the population is covered by employer-sponsored group health benefit plans. Les Christie, *Number of People Without Health Insurance Climbs*, CNN Money, Sept. 13, 2011; U.S. Census Bureau, *U.S. Census Bureau Announces 2010 Census Population Counts* (Dec. 21, 2010). In Massachusetts,

79% of insured residents receive their insurance through such employer-sponsored plans. *Key Indicators* 4. Moreover, as of 2011, 60% of ERISA plans in the nation were self-funded, Kaiser Family Found. & Health Research & Educ. Trust, *Employer Health Benefits Annual Survey* 151 (2011) (*Annual Survey*), and therefore fully beyond the reach of state regulation. *Aetna Health*, 542 U.S. at 208; *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (holding that ERISA preempted Pennsylvania's Motor Vehicle Financial Responsibility Law's application to self-funded health benefit plans).

A state's limited ability to regulate employer-sponsored group health plans, especially self-funded plans, impedes its capacity to comprehensively reform its health care and health insurance markets. In particular, ERISA makes it difficult for states to address the problems faced by employees who have insurance through work but remain underinsured, due to high deductibles, high co-pays or other limitations in their coverage. These problems only become more challenging as the number of underinsured employees increases. For example, the underinsured are more likely to be covered by high-deductible health plans. See Cathy Schoen et al., *Affordable Care Act Reforms Could Reduce the Number of Underinsured US Adults by 70 Percent*, 30 Health Affairs 1762, 1767 (2011) (finding that "the underinsured were more likely to report per person deductibles of $1,000 or more despite lower incomes"). The percentage of covered workers enrolled in high-deductible health plans increased

from 8% to 17% between 2009 and 2011. *Annual Survey* 5 (2011). That percentage is even higher, 23%, among workers in small firms with 3 to 199 employees. *Id.* Employee coverage in a high-deductible plan is most prevalent, 41%, among large firms of 1,000 or more employees. *Id.* As employees select high-deductible health plans in increasing numbers, more of them face the risk of underinsurance. Underinsurance, like uninsurance, can result in uncompensated care, or care that is delayed and delivered when it is more expensive. Sarah R. Collins, Commonwealth Fund, *The Problem of Underinsurance in the United States: What It Means for Working Families and How Health Reform Will Help* (2009) (explaining that while one purpose of health insurance is to provide timely access to medical services to prevent high cost illness later, the underinsured are more likely to delay or skip medical care due to high costs).

Massachusetts has found that despite Chapter 58, significant numbers of individuals offered employer-sponsored health insurance are underinsured and end up relying on state-subsidized health care. Currently, Wal-Mart Stores, Inc. (Walmart) has the highest number of employees utilizing state subsidized insurance in Massachusetts, but Walmart's group benefit plans are self-funded and thus covered by ERISA. Wal-mart Stores Inc., *2011 Annual Report* 35 (2011). In fiscal year 2009, 5,072 Walmart employees, plus 5,699 of their dependents, used state subsidized care in Massachusetts, incurring health care costs of approximately 16.6 million dollars. Div. of Health

Care Fin. & Policy, Mass. Exec. Office of Health & Human Servs. *Employers with 50 or More Employees Using Subsidized Care* app. 5, at 2 (2010) (*Subsidized Care*). This problem is not limited to Walmart; Massachusetts provides benefits to employees of many large, self-funded employers offering ERISA plans. For example, Target Corporation, another large employer in Massachusetts, offers self-funded group health insurance plans. Target Corp., *2010 Annual Report* 26 (2010). In fiscal year 2009, 2,204 Target employees, and 2,190 of their dependents, sought subsidized care from Massachusetts, receiving a total of 7.1 million dollars in subsidized care through MassHealth, Commonwealth Care, or the Health Safety Net. *Subsidized Care*. State subsidized health care under Commonwealth Care is also available to residents who do not have access to employer-sponsored health insurance, such as many part-time employees who are excluded from employer benefits plans. Mass. Gen Laws ch. 118H, § 3. Because of ERISA preemption, Massachusetts cannot require employers such as Walmart and Target to sponsor more generous group health insurance plans.

IV. The interstate nature of the health insurance and health care markets will cause problems for other states that try to achieve affordable, universal access to care.

Other states that seek to reform health care systems will face similar, if not greater, problems than Massachusetts has experienced due to federal law and the interstate nature of the health insurance and health care systems. Health care services are interstate economic activity across the country. The Dartmouth Atlas of Health Care compiled data as to where Medicare patients residing in a specific area are admitted for health care services. See The Dartmouth Atlas of Health Care, Dartmouth Inst. for Health Policy & Clinical Practice, *Data by Region* (2007). The Dartmouth Atlas has used this data to create maps referencing where residents in each area get the majority of their care. Hospital Service Areas (HSAs) show which hospitals patients from a certain area are likely to use for general care, and Hospital Referral Regions (HRRs) show where patients from a certain area are likely to have major procedures done. *Id*.

These HSAs and HRRs give a sense of the magnitude with which several states in the United States interlock with regard to health care services. While some HRRs in the Northeast include one or two states, HRRs in other regions stretch over a very wide area and may include several states. The Denver and Salt Lake City HRRs, for example, include sizeable

portions of three and five surrounding states, respectively. *Id.* The more states included in an HRR or HSA, the more difficult it is for individual state health reform efforts to achieve the goals set by state legislatures.

The success Massachusetts has experienced in enacting its health reform comes, in no small part, from its location in the New England region. The Northeast has the lowest percentage of uninsured in the country; see *U.S. Census Uninsured*, making it easier to implement workable health insurance reforms than in other regions. In fact, all six New England states were included among the fifteen states with the lowest rate of uninsurance during 2004 to 2006. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, at 24 tbl.6 (Aug. 2007). If Massachusetts were located next to a state with a much higher level of uninsured or underinsured individuals, the problems it has faced due to uninsured or underinsured out-of-state residents would have been greatly magnified. For example, Texas currently has 6.26 million uninsured people, approximately 25% of its population, Kaiser Family Found., *Health Insurance Coverage of the Total Population, States (2009-2010), U.S. (2010)*; placing even a fraction of these people next to Massachusetts would result in an explosion of costs due to uncompensated care in its hospitals.

Stark differences in adjoining states' health insurance regulations and number of uninsured can severely dilute the effectiveness of a state's attempts

to regulate health insurance within its borders. Utah's uninsured population, for example, numbers only about 422,000 (15.3% of 2.76 million total population). See U.S. Census Bureau, *U.S. Census Uninsured: Utah* (last revised Dec. 23, 2011). If Utah ever tried to decrease the number of uninsured within its borders through legislation, it could face a sizeable problem doing so, as it lies adjacent to two of the states with among the highest uninsured rates in the nation, Nevada and Arizona. See Paul Fronstin, Cal. HealthCare Found., *California's Uninsured* 3 (December 2010). These two states alone possess a combined total of 1.7 million uninsured people. See *id.* Since they are not residents of Utah, the State cannot require that they hold health insurance. Even if only a small portion of them enter Utah, they can undermine any health insurance reforms that that state might enact.

Almost every one of the states other than Alaska and Hawaii would face similar problems if they attempted a comprehensive reform of their own health care system. It is not entirely surprising then that Hawaii is the only other state with near universal health insurance coverage. Center for Health Policy Research, Okla. Med. Research Found., *Lessons Learned from Hawaiian Health Care Reform* 2 (Feb. 1992) (some analysts attribute Hawaii's successful reforms, in part, to "the very unique situation of being 3,000 miles from a competing border state"). Health care reform is inherently interstate commerce,

requiring federal coordination under the Commerce Clause.

CONCLUSION

Markets for health care and health insurance are enmeshed in interstate commerce because decisions individuals make in one state regarding whether to have and maintain health insurance inevitably affect other states. As a result of such decisions, states such as Massachusetts cannot solve their health care financing and delivery problems alone, even after they enact broad reforms such as Chapter 58. Only Congress can regulate across state lines; federal legislation such as the Act is therefore a clearly constitutional exercise of the Commerce Clause regulating interstate commerce.

The Court should reverse the Court of Appeals' decision and reverse the judgment of the Court of Appeals regarding the minimum coverage provision.

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