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 AARP AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

(MINIMUM COVERAGE PROVISION)

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QUESTION PRESENTED

This brief will address the following question:

Whether Congress had the power under Article I of the Constitution to enact the minimum coverage provision of the Patient Protection and Affordable Care Act, 26 U.S.C.A. § 5000A.

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STATEMENT OF INTEREST[1]

AARP is a nonpartisan, nonprofit organization dedicated to addressing the needs and interests of people aged 50 and older. Since its founding in 1958, AARP has advocated for affordable, accessible health care, as well as improved quality of care and controlled health care costs.

In response to the growing number of older people forgoing health care services and facing financial ruin due to health care and insurance becoming increasingly unaffordable and unavailable, AARP sought legislative solutions that would: protect Medicare benefits; reduce insurance rate disparities based on age or pre-existing conditions; reduce the rate of health care cost increases, including for prescription drugs; and eliminate waste, fraud, and abuse. Since 2007 AARP has collected thousands of personal accounts and testimonials from members and nonmembers describing the emotional and financial devastation they experienced when they were unable to pay for health insurance, were declined for insurance due to a prior illness, were unable to pay medical bills, or worse, were unable to receive necessary treatment or medicine when sick.

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[1] The parties have consented to the filing of this brief. No counsel for a party has authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus or its counsel made a monetary contribution to its preparation or submission.

When Congress was debating health reform legislation, AARP's advocacy focused on six key priorities: 1) Guaranteeing access to affordable coverage for Americans ages 50 to 64 in the individual market who have faced unaffordable insurance based on their age, pre-existing conditions, or health status; 2) Closing the Medicare Part D prescription drug coverage gap ("doughnut hole") so people are not forced to choose between paying for necessary medication and paying for other needed expenses; 3) Lowering drug costs by increasing availability of generic biologics, which are used to treat serious conditions like cancer, multiple sclerosis, anemia, and rheumatoid arthritis, and can cost as much as $10,000 or more per month; 4) Reducing costly hospital readmissions through a Medicare Transitional Care Benefit, which helps people safely transition to home or another setting after a hospital stay; 5) Increasing funding and eligibility for home and community based services for people with chronic conditions, which would save money, improve quality of life for individuals who need these services, and better enable them to live at home; and 6) Helping low-income Americans so that people who saved a small nest egg can still receive assistance with premiums and out-of-pocket health costs.

SUMMARY OF ARGUMENT

The Affordable Care Act's minimum coverage provision is a proper subject of political debate and disagreement. But the Constitution does not render the measure beyond the power of the people's representatives to enact.

I. The Affordable Care Act addresses a complex social and economic problem that affects all Americans, but particularly those ages 50 to 64. Indeed, the Act could be sustained solely on the basis of its effects on older Americans.

A. Individuals within this group face special difficulties in obtaining adequate insurance under the present system but are not yet eligible for Medicare and most do not qualify for Medicaid.

Pre-existing and Chronic Conditions. To start, nearly 75 percent of older Americans have a pre-existing condition or chronic illness before they become eligible for Medicare. The present insurance system systematically denies such individuals adequate, affordable insurance if they do not have access to coverage through an employer group. Often, they are simply denied any coverage at all. Even when they can get a policy, it frequently contains an exclusion for the pre-existing or chronic condition, leaving many without adequate insurance for the very health problems they are most likely to encounter. For their inadequate coverage, individuals in this age group who have pre-existing or chronic conditions must pay "rate-up" premiums of 20 to 80 percent greater than normal. The end result is that 70 percent of adults with pre-existing health conditions find it difficult, or

impossible, to find affordable health insurance in the private individual market.

Age Rating. Even the minority of adults aged 50 to 64 who do not have a pre-existing or chronic health condition are charged higher rates based solely on their age in the individual insurance market. In fact, A 60 year-old typically is charged 3 to 7 times as much as a 20 year-old for the same policy.

Annual and Lifetime Caps. Having paid excessive premiums for years, often for insurance with inadequate coverage, Americans aged 50 to 64 can find their claims denied precisely when they need it the most, due to low annual and lifetime caps on insurance benefits. Many policies have caps that are easily exceeded by a single serious illness, such as cancer or heart disease, or that quickly run out during the course of treatment for a chronic condition, like diabetes.

B. The lack of adequate insurance among members of this pre-Medicare age group has a substantial effect on the national economy. It effectively traps many older workers in their jobs for fear of losing their existing insurance, thereby impeding mobility in the national labor market, discouraging retirement, and preventing many older workers from leaving their jobs to start new businesses at the point in their careers when they have the most to offer as entrepreneurs.

In addition, those without adequate insurance frequently divert money from their retirement savings to pay medical bills, affecting the supply of savings that would otherwise be reinvested in the economy. At

the same time, spending in other areas is reduced, including for basic necessities. Reliance on credit cards and second mortgages also increases, often with ruinous results. Medical bills play a significant role in the majority of personal bankruptcies, an effect that has risen dramatically in recent years. The cost of those bankruptcies is placed on other creditors and businesses, with cascading effects for interstate commerce.

II. The uninsured have a substantial impact on federal spending programs as well, particularly on Medicare. The lack of adequate insurance leads many to forego basic preventative treatment and screenings in the years preceding their entry into the Medicare program. And in all too many cases, the uninsured are forced to postpone expensive treatment until the cost can be paid by the Government. The uninsured enter Medicare in worse health and require more expensive care than those who previously maintained insurance. Those additional costs ultimately are borne by federal taxpayers.

III. Congress was entitled to conclude that encouraging the majority of Americans to obtain insurance, through the imposition of a tax penalty for those who do not, was necessary to remove impediments to older Americans' full participation in the national economy and to account for the costs the uninsured impose on Medicare and other federal spending programs.

Without an increased insurance pool, the provisions of the Affordable Care Act reducing barriers to access to health insurance for people aged 50 to 64 – including those eliminating denials for pre-existing

and chronic conditions, and reducing age-rating disparities – would increase rates and make insurance even more unaffordable for many.

At the same time, Congress understood that those who voluntarily forego insurance, as a group, predictably impose great costs on both the medical system and federal spending programs. Congress could reasonably require those who choose to forego insurance to shoulder some portion of that financial burden through payment of a tax. In this light, the tax penalty associated with the minimum coverage provision is little different from taxes that fund government programs for unemployment insurance or disaster relief, taxes we all must pay whether we ultimately avail ourselves of the funded programs or not. And like a cigarette tax, the penalty for those who choose to forego available health insurance reasonably aims to discourage behavior that imposes enormous costs on our medical system, economy, and the federal budget.

ARGUMENT

I. The Affordable Care Act Has A Profound Effect On The Ability Of Americans Aged 50 To 64 To Participate In National Health Care, Labor, And Other Interstate Markets.

The number of Americans aged 50 to 64 without health insurance is growing at an alarming rate. In just 7 years, between 2000 and 2007, the number of such uninsured individuals grew more than 36 percent, from 5.2 million to 7.1 million persons.[2] By 2010, 8.9 million members of that age group were uninsured.[3] Many more have insurance that is grossly inadequate for their needs, often little better than no insurance at all. The consequences for families and the nation are devastating, distorting labor markets by trapping older workers in their jobs for fear of losing their insurance, draining retirement savings, and plunging families into unsustainable debt and sometimes bankruptcy.

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[2] Gerry Smolka et al., AARP Public Policy Inst. (PPI), *Health Care Reform: What's at Stake for 50- to 64-Year-Olds?* 1 (Mar. 2009), *available at* http://assets.aarp.org/rgcenter/health/i24_hcr.pdf.

[3] Gerry Smolka et al., AARP PPI, *Health Insurance Coverage for 50- to 64-Year-Olds* (forthcoming 2012) (manuscript at 1) (on file with authors) [hereinafter AARP PPI Report].

A. For Millions Of Older Americans Approaching Retirement, Health Insurance Has Become Unavailable Or Unaffordable.

Until they reach age 65, and become eligible for Medicare, most older Americans must obtain health insurance either from their employer or through the individual health insurance market.[4] For far too many, neither option offers any realistic opportunity to obtain the insurance they need.

1. Employer-Sponsored Health Insurance Is Frequently Unavailable Or Unaffordable For Older Americans.

Increasingly, older Americans cannot count on employers to provide adequate health insurance. Employers (particularly those with smaller businesses) have progressively reduced or eliminated health benefits for their workers.[5] Since 2000, the portion of

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[4] Most uninsured 50 to 64 year-olds are not eligible for either Medicare, the federal health insurance program for people age 65 or older (and that also covers some people under age 65 with disabilities and end-stage renal disease), or Medicaid, a joint federal and state run insurance program for low-income people with children or older dependents or who are disabled. Gretchen Jacobson et al., Kaiser Family Foundation, *Health Insurance Coverage for Older Adults: Implications of a Medicare Buy-In* 1 (Dec. 2009), *available at* http://www.kff.org/healthreform/upload/7904-02.pdf.

[5] *See, e.g.*, Robert Wood Johnson Foundation, *State-Level Trends in Employer-Sponsored Health Insurance* 24 (June 2011),

older adults with employer-sponsored health insurance has declined by 5.3 percentage points.[6] At the same time, even workers who do have employer-sponsored insurance have encountered rising health insurance costs through higher employee contributions, larger co-pays, or increased deductibles.[7]

Moreover, unemployment among older adults has risen markedly in the past several years.[8] And for the majority of adults who lose their jobs, that means becoming uninsured.[9] This is due in part to the

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available at http://www.rwjf.org/files/research/72528shadac201106.pdf.

[6] Smolka, AARP PPI Report, *supra* note 3, manuscript at 4 fig.3.

[7] *See, e.g.*, Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2011 Annual Survey* 67 (Sept. 2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf (average monthly premium paid for family coverage rose from $129 in 1999 to $344 in 2011).

[8] Nayla Kazzi & David Madland, *Mixed News for Older Workers*, Center for American Progress (Sept. 4, 2009), http://www.americanprogress.org/issues/2009/09/older_worker.html ("Workers 55 and older have a higher unemployment rate than any time since 1948"); E.S. Browning, *Oldest Baby Boomers Face Jobs Bust*, Wall Street Journal, Dec. 19, 2011, at A1, *available at* http://online.wsj.com/article/SB10001424052970204083204577080421127607002.html (in October 2011, 4.3 million Americans aged 55 to 64 were jobless or underemployed, nearly double the number just five years earlier).

[9] Sara R. Collins et al., The Commonwealth Fund, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief*, at ix (Mar. 2011), *available at* http://www.

extraordinary cost of obtaining individual insurance in the private market – older Americans who purchase health insurance themselves pay, on average, 2.5 times as much for their insurance as do those covered by an employer-provided policy.[10]

2. People Aged 50 to 64 Are Systematically Denied Coverage Or Priced Out Of The Individual Market Because Of Their High Incidences of Pre-Existing Conditions And Chronic Illness.

Even when insurance is nominally available in the individual market, many older Americans are effectively denied coverage by a system designed to minimize insurers' risk by "cherry pick[ing] healthy people" and "weed[ing] out those who are not as healthy." H.R. Rep. No. 111-443, at 990 (2010).

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commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Mar/1486_Collins_help_on_the_horizon_2010_biennial_survey_report_FINAL_v2.pdf.

[10] Smolka, AARP PPI Report, *supra* note 3, manuscript at 2 tbl.1. Those who lose their jobs may often obtain temporary coverage pursuant to provisions of the Consolidated Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. §§ 1161 *et seq*. But such coverage is time-limited and expensive, as the individual must pay the full premium, including the former employer's previous share. *See id*. § 1162(2), 1164. During the present recession, more than half of unemployed individuals aged 55 or older have failed to find a job in the 18 months during which COBRA generally extends coverage. *See id*. § 1162(2)(A)(i); Browning, *supra* note 8, at 1A.

As people age, they are more likely to have prior or existing medical conditions. While about one-third of 18 to 34 year-olds have one or more chronic conditions, more than three-quarters of 55 to 64 year-olds suffer from chronic illness.[11] Studies further estimate that between 48 and 86 percent of older individuals have a pre-existing health condition, compared to a rate of between 9 and 35 percent for younger people.[12]

Rather than pooling the risk of the young and the old, the healthy and the not-as-healthy, insurance companies in the individual market systematically deny coverage, limit benefits, or charge excessive premiums to individuals with pre-existing conditions and those older Americans perceived to be high-risk. Nearly 40 percent of people ages 50 to 64 with existing conditions or chronic illness who are seeking insurance in the individual market are either denied insurance,

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[11] Steven Machlin et al., Agency for Healthcare Research and Quality, *Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions*, *2005*, at 5 (May 2008), *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/st203/stat203.pdf.

[12] U.S. Dep't. of Health & Human Servs. (HHS), *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*, at fig.1, HealthCare.gov (Jan. 18, 2011), http://www.healthcare.gov/center/reports/preexisting.html (comparing rates of pre-existing conditions for individuals aged 55 to 64 compared to those aged 18 to 34).

charged a higher price, or have their condition excluded from coverage.[13]

Denial of Coverage. Last year, four of the largest insurance carriers reported to Congress that from 2007 through 2009, they had collectively denied coverage to more than 651,000 people because of their pre-existing conditions.[14] During that same short period, the rate of denials went up dramatically. The number of individuals denied coverage because of a pre-existing condition went up nearly 50 percent, even though applications for enrollment rose only 16 percent.[15]

Exclusion Of Pre-Exiting Conditions. In addition to simply denying coverage, insurers often issue policies with an exclusion or elimination rider under which services for a specific condition are temporarily or permanently excluded.[16] Commonly used exclusion

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[13] Sara R. Collins et al., The Commonwealth Fund, *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care Act of 2010*, at 3 (Dec. 2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Dec/1460_Collins_adults_50_to_64_ACA_reform_brief_v2.pdf.

[14] *See* Henry A. Waxman & Bart Stupak, U.S. House of Representatives, Comm. on Energy & Commerce, *Memorandum: Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market* 1 (Oct. 12, 2010), *available at* http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Pre-existing.Condition.Denials.Individual.Market.2010.10.12.pdf.

[15] *Id*.

[16] Mark Merlis, National Institute for Health Care Reform, *Health Coverage for the High-Risk Uninsured: Policy Options for*

and elimination riders effectively leave people who have acute or chronic illnesses in the same posture as they would be with no insurance. In part because of such exclusions, nearly 30 percent of people with individual insurance have inadequate coverage should they suffer a serious or catastrophic illness.[17]

Rate-Ups. Even when some coverage for pre-existing or chronic conditions is available, it is often offered at an increased, unaffordable cost. The so-called "rate-ups" for those with such conditions typically range from 20 to 80 percent above the base rate, depending on the applicant's medical history.[18] As a result, 70 percent of adults with a pre-existing health problem find it difficult or impossible to find affordable insurance on the individual market.[19]

Design of the Temporary High-Risk Pool 2 (May 2010), *available at* http://www.nihcr.org/High-RiskPools.pdf.

[17] H.R. Rep. No. 111-443, at 980 (citing to Consumer Reports, *Health Insurance: CR Investigates Health Care* (Sept. 2007)).

[18] Kaiser Family Foundation, *Understanding Individual Health Insurance Markets* (Mar. 17, 1998), http://www.kff.org/insurance/1376-barrierspr.cfm.

[19] Collins, *Help on the Horizon*, *supra* note 9, at xi ex.ES-2.

3. Age-Rating Has Made Insurance Premiums Particularly Unaffordable For Those Aged 50 to 64 Who Must Buy Insurance on the Individual Market.

Even setting aside pre-existing conditions and chronic illnesses, insurance is unaffordable for many older Americans simply because of their age.[20]

On average, even before health status is taken into account, AARP has found that a 60 year-old will pay between 3 and 7 times more than a 20 year-old for the same plan.[21] For example, AARP's review of premiums for policies starting on July 1, 2009 show that the best-selling insurance plan in Delaware charged a 20 year-old male $41 per month. The same plan cost a 60 year-old male $210 per month. In Florida, a 60 year-old man would pay 7.5 times the rate paid by a 20 year-old man ($286 per month compared to $38 per month). This practice of "age-

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[20] *See also* Karen Pollitz et al., Georgetown Univ. Inst. For Health Care Research & Policy, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* at iv (June 2001), *available at* http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumer-in-Less-Than-Perfect-Health-Report.pdf (finding that "[t]he standard rate for a healthy 62-year-old man was three to six times that for a healthy 24-year-old woman.").

[21] To obtain this data, AARP's Public Policy Institute researched rates offered within the various states via www.ehealthinsurance.com. The Institute obtained and then compared the rate for the best-selling plan available to a 60-year-old non-smoking male in a state against the rate for the identical plan when offered to a 20-year-old non-smoking male.

rating" was largely unregulated prior to the enactment of the Affordable Care Act – 32 states and the District of Columbia had no limit on age rating.[22]

Although there is an actuarial basis for charging older people higher premiums, they often are unable to afford the higher rates. Approximately half of uninsured people aged 55 to 64 live below 200 percent of the federal poverty line.[23] And as a group, uninsured older Americans are no better able to afford high premiums than any other age group. An analysis of the March 2008 Current Population Survey found that among uninsured adults, median family income is virtually identical across all age groups. For example, the median family income for uninsured 18 to 24 year-olds was $28,461, whereas it was $30,000 for uninsured 50 to 64 year-olds.[24] Yet, the combined effect of age-rating and increased premiums for those with pre-existing health conditions has meant that older individuals can pay 14 to 17 times as much as a

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[22] Kaiser Family Foundation, *Individual Market Rate Restrictions*, statehealthfacts.org (2011), http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=354; 42 U.S.C.A. § 300gg(a)(1)(A)(iii) (limiting age rating starting in 2014).

[23] *See* Jacobson, *supra* note 4, at 3.

[24] Lynn Nonnemaker, AARP Public Policy Inst., *Beyond Age Rating: Spreading Risk in Health Insurance Markets* 3 tbl.1 (Oct. 2009), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/i35-age-rating.pdf.

younger person for the same policy in the individual insurance market.[25]

4. Annual And Lifetime Caps Further Diminish Access To Insurance Benefits For Older Americans.

Older Americans are also disproportionately disadvantaged by annual and lifetime limits on insurance benefits that often cut off coverage precisely when it is needed the most. For example, Congress heard the following story of a 61 year-old woman from Florida:

> Kay works part time at a large department store earning $13,000 per year. She has insurance through her employer but quickly exceeded the plan's $25,000 annual maximum following her diagnosis with Stage II breast cancer. She has received eight cycles of pre-operative chemotherapy, had a lumpectomy with auxiliary lymph node dissection, and now needs radiation. Kay already has $40,000 in outstanding medical bills from various diagnostic tests that were not covered. Now she's been told that she cannot begin radiation

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[25] Nancy C. Turnbull & Nancy M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Findings from a Study of Seven States*, at vii (Feb. 2005), *available at* http://www.commonwealthfund.org/usr_doc/771_Turnbull_insuring_healthy_or_sick_findings.pdf.

> unless she plans to bring $115,000 with her to the first appointment.[26]

Low annual or lifetime caps can easily be exceeded by a single, common illness or accident. According to one study, "[a]mong common diagnoses, non-stroke neurologic illnesses such as multiple sclerosis were associated with the highest out-of-pocket expenditures (mean $34,167), followed by diabetes ($26,971), injuries ($25,096), stroke ($23,380), mental illnesses ($23,178), and heart disease ($21,955)."[27] Because the frequency of many such medical conditions naturally increases with age, older adults are particularly harmed by insurance caps.

B. The Lack Of Adequate Health Insurance For Americans Aged 50 To 64 Has A Substantial Effect On The National Economy.

The lack of adequate, affordable health insurance for older Americans has a profound effect on the national economy.

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[26] *The Instability of Health Coverage in America*: *Hearing Before the Subcomm. on Health of H. Comm. on Ways and Means*, 110th Cong. 89 (Apr. 15, 2008) [hereinafter *Hearings*] (statement of Stephen Finan, Assoc. Dir. of Policy, American Cancer Society).

[27] David Himmelstein et al., *Medical Bankruptcy in the United States, 2007*: *Results of a National Study,* 122 Am. J. Med. 741, 744 (2009), *available at* http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934309004045.pdf.

1. Lack Of Adequate Insurance Suppresses Mobility In The National Labor Market For Older Workers.

The present insurance system distorts interstate labor markets by discouraging workers, especially older workers, from leaving their jobs for fear of losing health care coverage.

Among those aged 51 or older, "nearly a quarter of career changers lose health benefits when they change jobs; only about 10 percent gain insurance."[28] Workers with chronic illnesses or pre-existing conditions – disproportionately older workers – are particularly reluctant to make any job changes that could impact health coverage for themselves, their spouses, or dependent family members. As a consequence, chronically ill workers, for example, are 40 percent less likely to leave their job if they get insurance through work compared to those who do not rely on their employers for coverage.[29]

The increasing concerns about losing insurance deters older workers not only from switching jobs, but even from reducing their hours or retiring. Even for those workers who turn 65 and are eligible for

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[28] Richard W. Johnson et al., AARP PPI, *Older Workers on the Move: Recareering in Later Life* 18 (2009), *available at* http://assets.aarp.org/rgcenter/ econ/2009_08_recareering.pdf.

[29] K.T. Stroupe et al., *Chronic Illness and Health Insurance-Related Job Lock*, 20 J. Policy Analysis and Mgmt. 525, 525 (2000), *available at* http://surface.syr.edu/cgi/viewcontent.cgi?article=1132&context=cpr.

Medicare, concerns about maintaining health insurance coverage for a younger spouse or dependent child (particularly one with a pre-existing condition) often prevents them from retiring, reducing hours, or switching jobs.[30]

The consequences for a dynamic economy are stark. Some of the nation's most valuable workers are discouraged from redirecting their talents to firms and sectors of the economy where they are most needed. At the same time, older workers are deterred from starting their own businesses for fear of being unable to obtain affordable insur ance, depriving the economy of the benefits of entrepreneurial activity by the most experienced segment of the workforce.[31]

2. Older Americans Lacking Adequate Insurance Divert Money From Retirement Savings To Pay For Medical Expenses.

Because they cannot obtain adequate, affordable insurance, many older Americans are forced to divert

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[30] *See* HHS, *supra* note 12; Sid Groeneman, AARP, *Staying Ahead of the Curve 2007: The AARP Work and Career Study* 23 (Sept. 2008), *available at* http://assets.aarp.org/rgcenter/econ/work_career_08.pdf.

[31] *See* Robert W. Fairlie et al., *Is Employer-Based Health Insurance a Barrier to Entrepreneurship?* 45-47 (Rand Corp., Working Paper No. WR-637-1-EMKF, 2010), *available at* http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR637-1.pdf (finding that job-lock has rippling effects in other corners of the economy because the threat of losing coverage restricts the formation of businesses effectively altering who can become entrepreneurs).

money from their retirement savings to pay for unreimbursed medical expenses, with predictable consequences for the national economy.

As they age, workers face an increased need to both set aside money for retirement and pay for medical care. Yet the lack of insurance, high deductibles, excessive co-pays, exclusions, and limits on annual and lifetime coverage make it likely that a great many older Americans will be forced to pay for medical expenses out of money that they otherwise would have been saving for their retirement. As one individual explained to AARP:

> I am 54 years old. Shortly after changing jobs from one I'd been at eight years the insurance company on the new job . . . denied coverage for pre-existing conditions because I was still in the enrollment period of about three months. This caused me to have to withdraw from my IRA and pay the 10% penalty. This money had been my retirement savings. I had to use it to pay the hospital bill.[32]

This experience is far from uncommon. One study estimated that 29 million people have used all of their savings on medical expenses.[33] Among those aged 50 to 64, the median household with a newly ill and

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[32] Sue B. from Decatur, Illinois, Statement to the AARP (Jan. 19, 2011).

[33] *See* Collins, *Help on the Horizon*, *supra* note 9, at 12.

uninsured member loses between 30 and 50 percent of the household's assets.[34]

This diversion of money from retirement savings naturally affects national credit markets, which depend in no small part on retirement savings to fund investment in our economy. And it inevitably leads to further undesirable effects throughout the economy as those individuals reduce non-health spending or become increasingly reliant on government assistance with housing costs, utilities, or food after retiring, the cost of which is a contributor to budget deficits that themselves have a substantial impact on credit markets and other aspects of our economy.[35]

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[34] Keziah Cook et al., *Does Major Illness Cause Financial Catastrophe?* 45 Health Services Research, No. 2, Apr. 2010, at 3, *available at* http://www.cfah.org/hbns/archives/viewSupportDoc.cfm?supportingDocID=830.

[35] *See, e.g.*, Barbara A. Butrica et al., The Urban Institute, *Do Health Problems Reduce Consumption at Older Ages*, at v (Mar. 2009), *available at* http://www.urban.org/UploadedPDF/411858_reduce_consumption.pdf (finding that "low-income adults in their fifties and early sixties appear to curtail their nonhealth spending in response to high health care expenses"); Neeraj Sood et al., HHS, *The Effect of Health Care Cost Growth on the U.S. Economy*, at pt. 3.3 (Sept. 2007), http://aspe.hhs.gov/health/reports/08/healthcarecost/report.html#33.

3. Medical Debt Is A Significant Source Of Financial Distress Among Older Americans, Causing Many Bankruptcies To The Detriment Of The Broader Economy.

At the same time, the national economy is equally affected when older Americans cannot pay for the medical services they have unavoidably consumed. In addition to the widely-recognized effect of distorting the market for medical services and insurance,[36] crushing medical debt often prevents older adults from paying other expenses, with cascading effects throughout the economy.

More than two-thirds of older adults who participate in the individual insurance market pay more than 10 percent of their income to medical costs.[37] Regardless of coverage status, for many – particularly those with low or modest incomes and with health problems – the financial burden can be much greater. Having to bear even a portion of the cost of many common medical conditions can be financially ruinous. A single illness or accident can easily cost more than the annual post-tax income of many families. Nearly a third of those with two or

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[36] *See, e.g.*, Pet. App. 11a-12a, 213a.

[37] Smolka, *What's at Stake for 50- to- 64-Year-Olds?*, *supra* note 2, at 2 tbl.1.

more emergency room visits or overnight hospital stays report problems paying the resulting bills.[38]

In the end, "one in four Americans (24 percent) say that paying for health care is a 'serious problem,'"[39] leaving them less able to purchase goods and services in other areas of the economy. One survey found that 22 million Americans report being unable to pay for basic necessities such as food, heat, or rent because of medical bills.[40]

Excessive medical debt also puts other businesses at financial risk. Millions of Americans have secured loans or taken on credit card debt to pay their medical bills.[41] Contributing to the current mortgage crisis, others took out first or second mortgages on their homes, precisely at the time they were least able to afford to pay the money back.[42] Unsurprisingly, in many cases, these desperate measures have resulted in personal bankruptcies.[43] One study found that medical debt caused or played a significant role in more than 62 percent of all bankruptcies in 2007, a

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[38] Kaiser Family Foundation, *Kaiser Health Tracking Poll: Election 2008*, at 2 (Aug. 19, 2008), *available at* http://www.kff.org/kaiserpolls/upload/7808.pdf.

[39] *Id*.

[40] Collins, *Help on the Horizon*, *supra* note 9, at 12.

[41] *Id*.

[42] *Id*.

[43] *Id*. (estimating 4 million medical-debt-related bankruptcies in 2010).

nearly 50 percent increase from 2001.[44] The financial cost of those bankruptcies is borne by mortgage holders, landlords, car dealers, credit card issuers, utilities, and small businesses throughout the economy. Increases in bankruptcy likewise predictably increase the cost of credit for consumers and small businesses.[45]

II. The Uninsured and Underinsured Have A Substantial Impact On Critical Federal Spending Programs.

The failure of individuals to obtain adequate medical insurance also has profound effects on federal spending programs, particularly Medicare.

By the time they reach age 65, the uninsured and underinsured enter Medicare in worse health, requiring more costly government-financed health care than do those who were previously insured.[46] One study showed that continuously uninsured people ages

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[44] Himmelstein, *supra* note 28, at 741.

[45] Congressional Budget Office, *Personal Bankruptcy: A Literature Review*, at vii (Sept. 2000), *available at* http://www.cbo.gov/ftpdocs/24xx/doc2421/Bankruptcy.pdf ("Losses stemming from bankruptcy . . . encourage lenders to boost their interest rates, tighten other standards and terms for lending, and reduce the availability of loans.").

[46] *See* J. Michael McWilliams et al., *Health Insurance Coverage and Mortality Among the Near-Elderly*, 23 Health Affairs 223, 227 (2004), *available at* http://content.healthaffairs.org/content/23/4/223.full.pdf+html (finding significantly higher mortality rates among the uninsured near-elderly than among the insured near-elderly).

52 to 61 were 63 percent more likely than insured people to have a decline in their overall health and 23 percent more likely to have a new physical difficulty that affected mobility such as walking or climbing stairs.[47] Even intermittently uninsured participants were at increased risk for declines in overall health and mobility.[48]

These results are unsurprising. Nearly two-thirds of uninsured adults aged 19 to 64 report that in the past year, they had cost-related problems accessing medical care – they failed to fill a prescription; did not see a specialist when needed; skipped a recommended medical test, treatment, or follow-up; or declined to visit a clinic or doctor for a medical problem.[49] Half of those with chronic conditions – such as high blood pressure, diabetes, lung disease, asthma, emphysema, or heart disease – did not fill a prescription or skipped doses of their medication because of cost.[50] Uninsured adults are also less likely than insured adults to receive preventive services or screenings, such as mammograms, pap smears, or prostate screening.[51]

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[47] David W. Baker et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 New Eng. J. Med. 1106, 1108 (2001), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa002887.

[48] *Id*. at 1111.

[49] Collins, *Help on the Horizon*, *supra* note 9, at 13 ex.14.

[50] *Id*. at 14 ex.16.

[51] Jill Bernstein et al., Mathematica Policy Research, Inc., *How Does Insurance Coverage Improve Health Outcomes?* 1 (Apr. 2010), *available at* http://www.mathematica-mpr.com/

The financial consequences for federal programs are direct and enormous. Avoidable illness and injury increase costs for Medicaid and the Supplemental Security Income (SSI) program, which provide health services and income support to many low-income individuals with serious health problems. In addition, "[n]ear-elderly adults who were uninsured required more intensive and costlier care in the Medicare program after the age of 65 years than previously insured adults . . . ."[52] "After becoming eligible for Medicare, uninsured adults have a rapid increase in physician visits and hospitalizations that persist for at least seven years after age 65."[53]

Some of the increased cost results from the uninsured or underinsured delaying necessary medical care until they become eligible for Medicare.[54] For example, a woman from Portsmouth, Virginia explained to AARP that:

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publications/pdfs/health/reformhealthcare_IB1.pdf; Collins, *Help on the Horizon*, *supra* note 9, at 15-17.

[52] J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 347 New Eng. J. Med. 143, 151 (2007), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa067712.

[53] *Hearings*, *supra* note 26, at 50 (statement of John Z. Ayanian, MD, Prof. of Med. and Health Care Policy, Harvard Med. School).

[54] Jacobson, *supra* note 4, at 1 (citing J. Michael McWilliams et al., *Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults*, 290 JAMA 757 (Aug. 2003), *available at* http://jama.ama-assn.org/content/290/6/757.full.pdf+html).

> When I turned 63 my insurer wanted to raise my rate to $934 a month, which I am solely responsible for paying. At the same time my doctor was trying to pin down a diagnosis for some hip pain I've been having. She wanted to do an MRI (cost $3000) but my insurance wouldn't cover it. She put me on a prescription drug to try and ease the pain; again the insurance company wouldn't cover it. . . . So I now pay for almost everything except limited doctor visits and my doctor is trying to control my hip pain until next year when I turn 65 and will be eligible for Medicare.[55]

For many, such delays in treatment lead to deteriorating health, the financial consequences of which are ultimately borne by Medicare.[56] This is particularly true with respect to individuals with hypertension, diabetes, heart disease, or stroke, where prevention and routine care can prevent costly acute care hospitalizations and interventions.[57] Uninsured adults with these chronic conditions report 13 percent more doctor visits, 20 percent more hospitalizations, and 51 percent higher total medical expenditures from ages 65 to 72 than previously insured adults.[58]

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[55] Valerie D. from Portsmouth, Virginia, Statement to the AARP (Sept. 17, 2010)

[56] McWilliams, *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, *supra* note 52, at 144.

[57] *See id*. at 145.

[58] *Id*. at 143.

Conversely, if more individuals had insurance coverage as they approached age 65, "the cost of covering them could be off-set by better health and potential savings for the Medicare program."[59] A study by PriceWaterhouseCoopers estimates that even taking the modest step of simply raising lifetime limits for private insurance would save Medicaid $11 billion over ten years.[60]

III. The Minimum Coverage Provision Is A Valid Exercise Of Congress's Article I Powers.

Congress has plenary authority to regulate conduct that has a substantial effect on interstate commerce,[61] to create federal spending programs to promote the general welfare,[62] and to impose taxes to pay for those programs.[63] Moreover, Congress retains the power to enact all legislation necessary and proper to implement its enumerated powers,[64] including the authority to regulate individual conduct that interferes with the operation of a comprehensive

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[59] *Hearings*, *supra* note 27, at 50 (statement of Dr. John Z. Ayanian).

[60] *See* PriceWaterhouseCoopers, *Impact of Lifetime Limits: Prepared for National Hemophilia Foundation* 5 (Mar. 2009), *available at* http://www.hemophilia.org/docs/LifetimeLimits Report.pdf.

[61] U.S. Const. art. I, § 8, cl. 3; *see also Gonzalez v. Raich*, 545 U.S. 1, 17 (2005).

[62] U.S. Const. art. I, § 8, cl. 1.

[63] *Id.*

[64] U.S. Const. art. I, § 8, cl. 18.

regulatory scheme that, considered as a whole, falls within Congress's authority.[65] While there can be legitimate debate whether the minimum coverage provision is fair or good policy, there is no basis for the court of appeals' conclusion that the Constitution takes the question out of the hands of the people's representatives.

A. Congress Reasonably Determined That Encouraging All Americans To Obtain Health Insurance Was Necessary To Make Feasible Other Measures That Removed Barriers To Americans' Access To Health Care Coverage.

There is no dispute that the health care crisis in our country is a proper subject of federal legislation. As described above and elsewhere, the rising cost of medical care and the inability to obtain adequate health insurance is a quintessentially national economic problem with profound effects on some of the largest and most important federal spending programs and tax expenditures. The minimum coverage provision held unconstitutional by the court of appeals is a necessary and proper component of a comprehensive solution to an intractable national problem.

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[65] *See, e.g.*, *Raich*, 535 U.S. at 17-18 (discussing Commerce Power and *Wickard v. Filburn*, 317 U.S. 111 (1942)); *Sabri v. United States*, 541 U.S. 600, 605 (2004) (Spending Power).

Individuals' failure to obtain health insurance, either from choice or unaffordability, is both a consequence and a cause of the present dysfunctional healthcare system. Congress rightly determined that it could not feasibly provide all Americans the opportunity to obtain affordable insurance unless it also encouraged them, through tax incentives, to participate in the insurance pool. Critical measures addressing the most significant impediments to health insurance for Americans aged 50 to 64 – including provisions barring insurers from denying coverage because of pre-existing conditions or considering health status in setting premiums,[66] and reducing allowable age-rating disparities[67] – would increase rates and make coverage unaffordable for many if not offset by an expansion of the insurance risk pool accomplished by the minimum coverage provision.[68]

In addition to the minimum coverage provision, Congress' goal of ensuring health insurance coverage for 95 percent of Americans by 2016 is facilitated by providing subsidies through tax credits to individuals who have difficulty affording insurance,[69] and expanding Medicaid coverage, almost entirely at

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[66] 42 U.S.C.A. §§ 300gg, 300gg-1(a).

[67] *Id*. § 300gg(a)(1)(A)(iii).

[68] *See* 42 U.S.C.A. § 18091(a)(2)(A); *see also*, *e.g.*, Jonathan Gruber, Ctr. for Am. Progress, *Health Care Reform Without the Individual Mandate* 2 (Feb. 2011), *available at* http://www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf.

[69] 26 U.S.C.A. § 36B(a)-(c).

federal expense.[70] By raising the income threshold, and extending eligibility to low-income adults with no dependent children, the Medicaid expansion is expected to make health coverage available to an estimated 3.3 million Americans aged 50 to 64 who currently have no insurance.[71]

B. Congress May Constitutionally Impose A Tax On Those Who Voluntarily Forego Health Insurance And, As A Consequence, Predictably Impose Greater Costs On Federal Spending Programs.

Congress's imposition of a tax on those who nonetheless forgo health insurance is neither unprecedented nor beyond its power. The federal government has long operated programs that spread common costs or risks to the public at large, financed through general, mandatory taxes. Medicare and Social Security are two examples. Other federal programs – including those that provide unemployment insurance, disability benefits, disaster relief, and drought assistance – similarly provide a form of public insurance that is financed through federal taxes we all must pay simply as a consequence of our residency in this country. No one questions Congress's authority to enact such programs under the

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[70] 42 U.S.C.A. §§ 1396a(a)(10)(A)(i)(VIII), 1396d(y)(1).

[71] Collins, *Realizing Health Reform's Potential*, *supra* note 13, at 12.

Spending Clause or to pay for them through its Taxing Power.

At the same time, Congress routinely, and justifiably, adjusts fees and taxes in light of the benefits a class of taxpayers receives and the class's responsibility for the cost of federal programs. Congress imposes a tax on cigarettes that both reflect the costs smoking imposes on federal programs like Medicare, and discourages behavior to reduce those costs.

The minimum coverage provision is no different. Those who forgo medical insurance are not penalized for "inactivity." They are instead required to bear some measure of the financial cost they will inevitably impose on others, including taxpayers, when they obtain medical care at government expense under Medicare or Medicaid or at the expense of a great many others if they ultimately require medical services for which they cannot pay.

In reality, all Americans benefit from federal healthcare programs and subsidies that bear the cost of medical care for many of the uninsured, as well as the general legal and moral mandate that no one should be denied critical medical care because of inability to pay. The voluntarily uninsured engage in all manner of conduct – including quintessential interstate economic activity – that risks injury or disease.[72] Even if not immediately realized, that risk

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[72] *See, e.g.*, U.S. Bureau of Labor Statistics, *Fatal Occupational Injuries and Nonfatal Occupational Injuries and*

is properly seen as having a real and present cost. And the assurance of the future availability of medical care should those inherently risky activities lead to injury or illness is a present benefit.[73]

Congress is not constitutionally obligated to turn a blind eye to the fact that if these risks are not insured, much of their costs inevitably will be borne by taxpayers and the broader economy. That is the same rational economic insight that leads landlords to demand security deposits, homeowners to seek bonded plumbers, and legislatures to require drivers, lawyers, and business owners to carry liability insurance. To be sure, one often can avoid those requirements by declining to engage in certain conduct. But the fact that there is ultimately no way to avoid the risks insured by medical coverage does not change the facts that the risk exists, is costly, and if not insured will all too often end up being paid for by someone else.

Of course, though the number is extremely small, there may be some people who would prefer not to purchase insurance *and* will never, in fact, rely on a

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Illnesses, 2008, at Chart 15, *available at* http://www.bls.gov/iif/oshwc/osh/os/oshs2008_15.pdf (reporting 3.7 million private sector work-related injuries and illnesses in 2008); U.S. Nat'l Highway Traffic Safety Admin., *Trends in Non-Fatal Traffic Injuries: 1996- 2005*, at 5 (May 2008), *available at* http://www-nrd.nhtsa.dot.gov/Pubs/810944.pdf (estimating more than 2.5 million injuries from traffic accidents in 2005).

[73] *Cf. Lorance & AT&T Tech., Inc.*, 490 U.S. 900, 907 n.3 (1989) (recognizing that insurance policy has present value even if harm it insures against has not yet occurred).

government program or default on a medical bill. But Congress may exercise its Article I power categorically.[74] A smoker is required to pay the cigarette tax whether he personally contributes to increased national health care costs or not. And the Government may require even very careful airlines to carry insurance.[75] Similarly, those who may not anticipate receiving disaster relief, Social Security, Medicaid, or Medicare must still pay taxes that help support those programs.

That Congress has given individuals the choice of avoiding the tax by obtaining insurance that reduces the need for federal expenditures is a virtue, not a vice. Congress rejected proposals that would have established a national medical insurance program, under which all Americans could be required to contribute to its upkeep through general taxes. Congress chose instead to build upon the nation's private system of insurance, affording individuals greater choice.

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The minimum coverage provision has been a topic of sustained public attention and political debate. That is as it should be. The Constitution properly leaves the politically accountable branches broad leeway to address complex national problems. It is the role of the people, not the courts, to decide whether Congress has struck the right balance in this case.

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[74] *See*, *e.g.*, *Raich*, 545 U.S. at 17.

[75] *See* 14 C.F.R. §§ 205.1-205.5.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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