
No. 11-1057

United States Court of Appeals
for the Fourth Circuit

COMMONWEALTH OF VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II,
IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF VIRGINIA,
Petitioner and Appellee,

v.

KATHLEEN SEBELIUS, SECRETARY OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES, IN HER OFFICIAL CAPACITY,

Respondent and Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

**AMICUS BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS
IN SUPPORT OF APPELLANT**

MARTHA COAKLEY
*Attorney General
of Massachusetts*

Frederick D. Augenster, BBO # 553102
Thomas M. O'Brien, BBO # 561863
Daniel J. Hammond, BBO # 559475
Assistant Attorneys General
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200, ext. 2427
email: fred.augenster@state.ma.us

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICUS 1

ARGUMENT 5

A. THE EXPERIENCE OF MASSACHUSETTS CONFIRMS THAT CONGRESS HAD A RATIONAL BASIS TO DETERMINE THAT FREE-RIDING, TAKEN IN AGGREGATE, SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE; ACCORDINGLY, CONGRESS HAD AUTHORITY UNDER THE COMMERCE CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT. 5

B. BECAUSE ELIMINATING FREE-RIDERS IS, AT A MINIMUM, RATIONALLY RELATED TO SUCCESSFUL IMPLEMENTATION OF OTHER COMPONENTS OF FEDERAL HEALTHCARE LAW, CONGRESS ALSO HAD AUTHORITY UNDER THE NECESSARY AND PROPER CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT. 10

CONCLUSION..... 15

TABLE OF AUTHORITIES

Cases

Gonzales v. Raich, 545 U.S. 1 (2005).....5, 6, 7

McCulloch v. Maryland, 4 Wheat 316 (1819).....11

United States v. Comstock, ___ U.S. ___,
130 S.Ct. 1949 (2010).....10, 11

United States v. Lopez, 514 U.S. 549 (1995).....7

United States v. Morrison, 529 Mass. 598 (2000).....7

United States v. South-Eastern Underwriters
Ass’n, 322 U.S. 533 (1944).....6

Wickard v. Filburn, 317 U.S. 111 (1942).....6

Federal Statutes

29 U.S.C. §§ 1001 et seq.11

42 U.S.C. §§ 201 et seq.11

42 U.S.C. § 1395dd.....7

Pub. L. No. 93-406, § 2.....13

Pub. L. No. 111-148, § 1201 (March 23, 2010).....11

Pub. L. No. 111-148, § 1501(a)(2)(F) (March 23,
2010).....6

Pub. L. No. 111-148, § 1501(a)(2)(H) (March 23,
2010).....11

Pub. L. No. 111-148, § 1501(a)(2)(I) (March 23,
2010).....12

Massachusetts Statutes

St. 2006, c. 58.....1, 2, 4, 14

Constitutional Provisions

U.S. Const., art. I, § 8, cl. 3.....5

U.S. Const., art. I, § 8, cl. 18.....10

Miscellaneous

Blue Cross Blue Shield Found., Health Reform in Massachusetts: An Update as of Fall 2009 (June 2010), available at, <http://bluecrossfoundation.org/~media/Files/Publications/Policy%20Publications/060810MHR2009FINAL.pdf>.....3, 8, 9, 10

Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators (Nov. 2010), available at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_november_2010.pdf.....13

Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report (July 2007).....4, 8

Division of Health Care Finance and Policy, 2009 Annual Report: Health Safety Net (Dec. 2009).....4, 8

House Bill 4279, 184th Gen. Ct. (Mass. 2005)2, 3

Josh Goodman, Washington Health Policy Week in Review Massachusetts: A Model, or Cautionary Tale?, Wash. Health Pol’y Wk. in Rev. (The Commonwealth Fund), June 8, 2009, available at, <http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Jun/June-8-2009/Massachusetts-A-Model-or-Cautionary-Tale.aspx>9

Mass. Taxpayers Found., Massachusetts Health Reform: The Myth of Uncontrolled Costs (May 2009), available at, <http://www.masstaxpayers.org/sites/masstaxpayers.org/files/Health%20care-NT.pdf>3, 8

William Pierron & Paul Fronstin, ERISA Pre-emption: Implications for Health Reform and Coverage 314 EBRI Issue Brief 11 (Feb. 2008), available at, http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.....13

INTEREST OF THE AMICUS

In 2006, the Commonwealth of Massachusetts passed and implemented *An Act Providing Access to Affordable, Quality, Accountable Health Care*, Chapter 58 of the Acts of 2006 ("Chapter 58"), thereby becoming the first State in the Nation to enact healthcare reform that requires all non-exempt individuals to purchase some form of health insurance coverage. Chapter 58's core features include, among other things, a state-operated health insurance exchange, new subsidies for low- and moderate-income individuals, and a mandate that all individuals who can afford health insurance purchase coverage. Chapter 58 has been widely cited as a model used by Congress in fashioning what became the Patient Protection and Affordable Care Act (the "ACA"). With four years of empirical data collected since Chapter 58 went into effect, Massachusetts is uniquely situated to speak to the actual economic effects of comprehensive reform that includes an individual coverage requirement.

The experience of Massachusetts under Chapter 58 confirms a key Congressional assumption underlying the ACA: that by requiring individuals to be insured, and thereby preventing healthy people from foregoing health insurance until they are sick or injured (a practice commonly derided as "free-riding"), a comprehensive reform program can spread risk, control costs, and reduce the financial burdens otherwise borne by health plans

and free-care pools. Massachusetts submits this amicus brief in support of the ACA because its experience demonstrates that Congress had a rational basis for concluding that free-riding by individuals, taken in aggregate, has a substantial effect upon interstate commerce, and that reducing or eliminating free-riding has a salutary impact on the health insurance market as a whole.

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

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

Governor Romney's proposed legislation to enact "Safety Net Care" was the precursor to Chapter 58, which he signed on April 12, 2006.²

¹Letter from Governor Mitt Romney to the Massachusetts Legislature dated July 20, 2005, filing proposed health reform entitled, An Act to Increase the Availability and Affordability of Private Health Insurance To Residents of the Commonwealth. H.B. 4279, 184th Gen. Ct. (Mass. 2005).

²Under Governor Romney's proposed legislation, "Safety Net Care" was the term used for a proposed government subsidized premium assistance offered to low-income individuals who were not
(footnote continued)

The Massachusetts healthcare reform law has resulted in positive economic consequences. Three years after its enactment, Massachusetts had reduced the number of uninsured residents to less than three percent of the state's population and increased the number of residents with health insurance by more than 432,000, giving Massachusetts the lowest rate of uninsured residents in the Nation.³ By the fall of 2009, more than 95 percent of nonelderly Massachusetts adults were insured, up from 87.5 percent in the fall of 2006.⁴ The significant gains in the number of Massachusetts residents with health insurance helped spur a corresponding sharp decline in the amount of state spending on "free care" for the uninsured and under-insured.

(footnote continued)

eligible for Medicaid. H.B. 4279, 184th Gen. Ct. (Mass. 2005). assistance offered to low-income individuals who were not eligible for Medicaid. H.B. 4279, 184th Gen. Ct. (Mass. 2005).

³See Mass. Taxpayers Found., Massachusetts Health Reform: The Myth of Uncontrolled Costs 2 (May 2009), available at, <http://www.masstaxpayers.org/sites/masstaxpayers.org/files/Health%20care-NT.pdf> [hereinafter Mass. Taxpayers Found.].

⁴See Blue Cross Blue Shield Found., Health Reform in Massachusetts: An Update as of Fall 2009 iv (June 2010), available at, <http://bluecrossfoundation.org/~media/Files/Publications/Policy%20Publications/060810MHR2009FINAL.pdf> [hereinafter BCBS Found. Report]. Indeed, insurance coverage rose by 14.1 percentage points for lower-income adults and 6.6 percentage points for adults with a chronic health condition between fall 2006 and fall 2009. Id. at v.

The amount of free care dropped from \$709.5 million in fiscal year 2006 to \$414 million in fiscal year 2009.⁵

Despite these successes under Chapter 58, however, Massachusetts, like any individual state, is unable to grapple effectively with the interstate (and international) economic implications of current healthcare trends. While Massachusetts plays the primary role in protecting the health and welfare of Massachusetts residents, the state shares responsibility for regulating healthcare and health insurance with the federal government. Through Medicare, Medicaid, and a variety of federal statutes, notably the Employee Retirement Income Security Act of 1974 (ERISA), the federal government plays a substantial (and, in some areas, exclusive) role in shaping the nationwide healthcare marketplace. Given this overlay, some aspects of healthcare reform are beyond individual states' regulatory reach. For example, Massachusetts's ability to regulate the private group health plan market in Massachusetts is constrained by ERISA, which preempts state governments from enacting laws that regulate self-insured employer health benefit plans, the most common source of health coverage for American workers.

⁵See Division of Health Care Finance and Policy, 2009 Annual Report: Health Safety Net 4 (Dec. 2009); Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report 3 (July 2007).

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

ARGUMENT

A. THE EXPERIENCE OF MASSACHUSETTS CONFIRMS THAT CONGRESS HAD A RATIONAL BASIS TO DETERMINE THAT FREE-RIDING, TAKEN IN AGGREGATE, SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE; ACCORDINGLY, CONGRESS HAD AUTHORITY UNDER THE COMMERCE CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT.

The Commerce Clause provided Congress with authority to enact the ACA, including the minimum coverage requirement. The Constitution gives Congress the power to "regulate Commerce . . . among the several States." U.S. Const., art. I, § 8, cl. 3. Under this authority, Congress can "regulate activities that substantially affect interstate commerce."⁶ Gonzales v. Raich, 545 U.S. 1, 17 (2005).

As "stressed" by the Supreme Court, "[i]n assessing the scope of Congress' authority under the Commerce Clause . . . the task before [the Court] is a modest one." Id. at 22. The Court "need not determine" itself whether the regulated "activities,

⁶ Congress also has the authority to "regulate the channels of interstate commerce" and to "regulate and protect the instrumentalities of interstate commerce and persons or things in interstate commerce." Gonzales, 545 U.S. at 16-17.

taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." Id.

There is a rational basis for concluding that, taken in the aggregate, individuals' refusal to obtain health insurance substantially affects interstate commerce. "[T]he business of insurance" is within "the regulatory power of Congress under the Commerce Clause." United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 553 (1944). In the ACA, Congress found that:

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

ACA § 1501(a)(2)(F), as amended by § 10106.⁷ "It is well established by decisions of [the Supreme] Court that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices." Wickard v. Filburn, 317 U.S. 111, 128 (1942) (upholding, as a proper subject of Congressional action under the Commerce Clause, a regulation penalizing production of

⁷ Such Congressional findings are to be considered in the analysis when available, although they are not necessary to sustain the exercise of Commerce Clause authority. Gonzales, 545 U.S. at 21.

wheat in excess of federal quota, even where applied to wheat grown not for market, but for consumption at home). Because it directly impacts the prices at which health insurance policies will be sold, individuals' refusal to obtain health insurance is a practice properly subject to regulation by Congress under the Commerce Clause.⁸

The experience in Massachusetts elevates the connection between eliminating free-riders and controlling costs from a rational belief to a demonstrable correlation. Governor Romney and the Massachusetts Legislature, like Congress, determined that an individual health insurance mandate, as part of a comprehensive reform package, would serve to increase access to healthcare while greatly decreasing the detrimental cost-shifting caused by people who chose to forego insurance and shift the cost of their current and future healthcare to others.⁹ As discussed above, in the three years after Chapter 58's enactment, there was, indeed, a significant increase in the

⁸ As in Gonzales, 545 U.S. at 25-26, the earlier Supreme Court decisions in United States v. Lopez, 514 U.S. 549 (1995), and United States v. Morrison, 529 U.S. 598 (2000), are distinguishable as they relate to non-economic behavior.

⁹ Federal law, in fact, requires Medicare-participating hospitals with an emergency department to provide emergency services to stabilize patients with emergency medical conditions regardless of whether they are insured. See 42 U.S.C. § 1395dd (2006).

percentage of insured Massachusetts residents.¹⁰ The significant gains in the number of Massachusetts residents with health insurance helped spur a corresponding sharp decline in the amount of spending on "free care" for the uninsured and underinsured: The amount of free care dropped 40% -- hundreds of millions of dollars -- from fiscal year 2006 to fiscal year 2009.¹¹

The Massachusetts reform program also has improved healthcare use. From the fall of 2006 to the fall of 2009, more adults (including lower-income adults, adults with chronic health conditions and minority adults) reported visits to doctors and fewer adults reported unmet need for care.¹²

Massachusetts achieved these gains in access to care while making gains in the affordability of care for its residents. In the fall of 2009, as compared with the fall of 2006, and notwithstanding the systemic impacts of the economic recession, there were reductions in both the share of adults reporting high out-of-pocket healthcare spending relative to family income and

¹⁰See Mass. Taxpayers Found., supra note 3; BCBS Found. Report, supra note 4, at 10.

¹¹See Division of Health Care Finance and Policy, 2009 Annual Report: Health Safety Net 4 (Dec. 2009); Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report 3 (July 2007).

¹²BCBS Found. Report, supra note 4, at 10.

the share of adults reporting unmet needs for care due to cost.¹³ Moreover, nearly 200,000 of the state's newly insured residents are enrolled in private plans that do not receive government subsidies, evidence that the more generous public programs created under Chapter 58 are not supplanting the state's existing health insurance providers.¹⁴ Analysis from 2009 also demonstrates that the state's individual health insurance requirement is encouraging people who were previously eligible for employer-based insurance, but did not previously accept it, to enroll in a private plan.¹⁵

As the experience with healthcare reform in Massachusetts shows, prohibiting people from opting out of the insurance market when they can afford coverage, and creating incentives for these "free-riders" to join their employer-sponsored health plan or to enroll in a publicly supported healthcare plan, has helped generate "increases in both public and private insurance coverage, and this increase in coverage has translated into

¹³BCBS Found. Report, supra note 4, at 10.

¹⁴See Josh Goodman, Washington Health Policy Week in Review Massachusetts: A Model, or Cautionary Tale?, Wash. Health Pol'y Wk. in Rev. (The Commonwealth Fund), June 8, 2009, available at, <http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Jun/June-8-2009/Massachusetts-A-Model-or-Cautionary-Tale.aspx>.

¹⁵ Id.

increases in the access, use, affordability, and quality of care in the state.”¹⁶

B. BECAUSE ELIMINATING FREE-RIDERS IS, AT A MINIMUM, RATIONALLY RELATED TO SUCCESSFUL IMPLEMENTATION OF OTHER COMPONENTS OF FEDERAL HEALTHCARE LAW, CONGRESS ALSO HAD AUTHORITY UNDER THE NECESSARY AND PROPER CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT.

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

As with the analysis under the Commerce Clause, the standard for determining whether legislation is authorized under the Necessary and Proper Clause is a relaxed one. Enactment of a particular federal law is authorized by the Necessary and Proper Clause when “the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power.” United States v. Comstock, ___ U.S. ___, 130 S.Ct. 1949, 1956 (2010). In Comstock, the Court reiterated its nearly 200-year-old formulation on this issue, originally expressed by Chief Justice Marshall, that the Necessary and Proper Clause is a “broad power to enact laws that are

¹⁶BCBS Found. Report, supra note 4, at 50.

'convenient, or useful' or 'conducive' to the . . . 'beneficial exercise'" of specifically granted powers. 130 S.Ct. at 1956 (quoting McCulloch v. Maryland, 4 Wheat 316, 413, 418 (1819)).

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

First, Congress found that:

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

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

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

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

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

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

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

There remains a limit, however, to the structural changes Massachusetts can effect in the healthcare marketplace, given the constraints resulting from state jurisdictional limits and imposed by long-established federal law. Massachusetts cannot effectively account for, let alone mitigate, the interstate (and international) economic implications of current healthcare trends. Healthcare access and affordability significantly affect interstate activity, including where people choose to

reside and how they obtain coverage and treatment. Congress has long recognized that, at a minimum, employer health plans had “operational scope and economic impact” that was “increasingly interstate.”¹⁷

The federal government already exercises significant control over a large section of the private group health plan market. In Massachusetts, more than half of this market is made up of self-insured plans that, because of ERISA’s preemptive effect, are beyond the direct reach of state regulators.¹⁸ Nationwide, the number of people enrolled in these self-insured employer plans has increased markedly since 1999. In 2007, 55 percent of the 132.8 million people in plans governed by ERISA were in self-insured plans, up from 44 percent in 1999.¹⁹ The federal government has long exercised exclusive regulatory authority over these self-insured employer benefit plans. The continued growth of self-insured plans, coupled with the

¹⁷ERISA, Pub. L. No. 93-406, § 2.

¹⁸The “private group market” includes large group, small group, and self insured members. See Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, 4, 6 (Nov. 2010), available at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_november_2010.pdf.

¹⁹See William Pierron & Paul Fronstin, ERISA Pre-emption: Implications for Health Reform and Coverage 314 EBRI Issue Brief 11 (Feb. 2008), available at, http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

interstate nature of the healthcare marketplace, demonstrate the need for the federal reforms contained in the ACA to establish minimum national standards for health coverage. The ACA specifically provides that individual states remain free to further regulate intrastate aspects of the health insurance market, including reforms similar to those implemented in Massachusetts under Chapter 58, if they so choose.

The success of Massachusetts healthcare reform demonstrates the economic benefits of tackling the free-rider problem head-on, through comprehensive reform including a requirement that individuals who can afford health insurance must purchase it. The experience of Massachusetts shows that the minimum coverage requirement in the ACA was, at least, rationally related to Congress's effort pursuant to the Commerce Clause to address the interstate implications of healthcare access and affordability.

CONCLUSION

For these reasons, Massachusetts urges this Court to hold that Congress had the constitutional authority to enact the Patient Protection and Affordable Care Act.

Respectfully submitted,

COMMONWEALTH OF MASSACHUSETTS,
by and through its
ATTORNEY GENERAL,
MARTHA COAKLEY

/s/ Frederick D. Augenstern
Frederick D. Augenstern
BBO # 553102
Thomas M. O'Brien
BBO # 561863
Daniel J. Hammond
BBO # 559475
Assistant Attorneys General
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200
 ext. 2427 (Augenstern)
 ext. 2455 (O'Brien)
 ext. 2078 (Hammond)
fred.augenstern@state.ma.us

March 7, 2011

CERTIFICATE OF COMPLIANCE WITH F.R.A.P. 32(a)

I, Frederick Augenstern, hereby certify that the attached brief of amicus curiae complies in all material respects with the requirements set forth in F.R.A.P. 28.1(e) and F.R.A.P. 32(a). It is printed in Courier New typeface, size 12 (text and footnotes). The brief contains 2,572 words, including the signature block but exclusive of cover, tables, and certificates.

/s/ Frederick D. Augenstern
Frederick D. Augenstern
Assistant Attorney General

CERTIFICATE OF SERVICE

I, Frederick Augenstern, hereby certify that I caused a true and accurate copy of this brief of amicus curiae to be electronically served upon all parties listed on this Court's ECF system on March 7, 2011. I further certify that I caused eight paper copies (including one original) of this brief to be filed with the Clerk of this Court, by regular mail, on March 7, 2011.

/s/ Frederick D. Augenstern
Frederick D. Augenstern
Assistant Attorney General