No. 11-398

In The
Supreme Court of the United States

Department of Health and Human Services, et al.,
Petitioners,
v.
Florida, et al., *Respondents*

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

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BRIEF AMICI CURIAE OF DAVID R. RIEMER AND COMMUNITY ADVOCATES IN SUPPORT OF PETITIONERS ON THE MINIMUM COVERAGE QUESTION

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INTEREST OF THE AMICI CURIAE

David R. Riemer and Community Advocates join in this brief in support of the petitioners in No. 11-398 (Department of Health and Human Services, et al. v. Florida, et al.) with respect to the minimum coverage question.[1]

Community Advocates (CA), founded in 1976, provides basic needs and advocacy services each year to tens of thousands of low-income, at-risk individuals and families in the Milwaukee area. The organization's services include health insurance advocacy. Every year, CA helps impoverished and uninsured Milwaukeeans to enroll in Wisconsin's Medicaid program and assists those ineligible for the program to find alternative ways of obtaining medical care.

David Riemer, Senior Fellow at the Community Advocates Public Policy Institute, is a health policy expert who has worked for over 35 years to create state and federal policies that expand health care

[1] No counsel for any party authored this brief in whole or in part. Neither counsel for any party, nor any party, made a monetary contribution intended to fund the preparation or submission of this brief.

coverage to low-income workers and control health care costs.[2]

In the 1970s, Riemer drafted Wisconsin's first Medicaid rule during the Administration of former Wisconsin Governor Patrick Lucey. He also worked on drug regulation and mental health policy reform for the U.S. Senate Subcommittee on Health and Scientific Research, chaired by the late Senator Edward Kennedy. Returning to Wisconsin in the 1980s, he helped to draft legislation that converted the state employee health plan into a large and long-lasting health insurance exchange.

While serving in the 1990s as budget director and administration director for Milwaukee Mayor John Norquist, Riemer teamed up with the Administration of former Wisconsin Governor Tommy Thompson to design the state's BadgerCare program. BadgerCare weaves together the portion of Medicaid that serves the poorest uninsured children and custodial parents with the State Children's Health Insurance Program (SCHIP) to greatly

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[2] *See generally* http://ca-ppi.org (providing additional information on David Riemer and the Community Advocates Public Policy Institute).

expand coverage for low-income families.

In 2003, as State Budget Director for former Wisconsin Governor Jim Doyle, Riemer worked to further improve the state employee health plan's exchange mechanism. From 2004 through 2007, as head of the Wisconsin Health Project, he coordinated the development of bi-partisan legislation to create a comprehensive state health insurance plan, which was folded into a bill passed by the Wisconsin State Senate.

In 2008, Riemer joined CA to lead its Public Policy Institute (PPI), and is now a Senior Fellow. Drawing on CA's experience in directly assisting poor people, and seeking to create for the poor and non-poor alike a rational system of comprehensive and affordable health insurance, Riemer and CA have worked to bring about policy changes at the state and national level. Their goal has been to persuade policy-makers to enact laws that expand health insurance coverage to the low-income uninsured population, control health insurance costs, and improve the quality of health care. Much of Riemer's and CA's work has focused on the ACA.

Specifically, Riemer and CA have played a major role in Wisconsin, and a significant role nationally, in advocating for: (1) the expansion of BadgerCare coverage to low-income non-custodial parents, both in advance of and pursuant to the ACA's extension of Medicaid to this group; and (2) the adoption of federal and state policies for the insurance exchanges created by the ACA that will enable them to be effective in covering uninsured individuals between 133% and 400% of the Federal Poverty Level (FPL), assisting small employers to obtain affordable coverage for their employees, and holding down health insurance costs while improving health care quality.

The position that Riemer and CA have taken on health insurance exchanges is unique. Typically, advocates for the low-income population have favored non-market models of health insurance reform (such as a "single payer" plan, the expansion of Medicare, or the inclusion of a "public option") that critics often labeled as "socialized medicine." In contrast, Riemer and CA have supported an evidence-based mechanism for organizing *private market forces*—choice, competition, and incentives—

to induce private insurance companies to hold down health insurance costs and improve the quality of health care. Drawing on official data that demonstrate that the marketplace competition model used by the Wisconsin state employee health plan in Dane County has lowered health insurance premiums by approximately $1,000 for individual coverage and $3,000 for family coverage (compared to the state's other 71 counties), Riemer and CA have advocated for the adoption of the Dane County model by the ACA and states' exchanges. Doing so, they have argued, will stimulate competition in the private insurance market, lower costs and improve health quality.[3]

Thus, instead of championing a regulatory approach, Riemer and CA urged federal policy-makers during the debate on the ACA in 2009-

[3] See, *e.g.,* David R. Riemer and Alain Enthoven, *The Only Public Health Plan We Need,* New York Times (June 24, 2009), http://www.nytimes.com/2009/06/25/opinion/25enthoven.html; David R. Riemer, *Prescription for a Health Insurance Compromise: Forget the Public Option and Co-ops, Rewire the Exchange,* Committee for Economic Development (September 24, 2009), http://www.ced.org/commentary/65-commentary/378-prescription-for-a-health-insurance-compromise-forget-the-public-option-and-co-ops-rewire--the-exchange.

2010—and state policy-makers since 2010—to design state health insurance exchange "pools" that, as in the Dane County experience, were (1) average in risk, (2) very large in size (approximately 25% of the county's population not enrolled in Medicaid or Medicare), and (3) composed of participants who had extensive choice among competing health care but also clear economic incentives to select the low-cost plan.[4] They argued that the evidence showed that such a market-oriented approach would create the kind of stern and lasting discipline of the health insurance market that is needed to constrain costs and upgrade quality.[5]

Advancing these positions on the uninsured and exchanges, Riemer served in 2010 and 2011 on the Wisconsin Legislative Council Special Committee on Health Care Reform Implementation, as well as on the National Association of Social Insurance (NASI) Study Panel on Health Insurance Exchanges. In 2011, CA launched a Project for Health Insurance Exchange Education (PHIXE) to provide technical

[4] *Id.*
[5] *Id.*

support to state policy-makers to design exchanges that are effective in controlling costs.

The low-income, uninsured individuals and families that CA serves, and on whose behalf Riemer and CA work, will benefit greatly if the ACA's minimum coverage provision in dispute in this case is upheld.

If the minimum coverage provision is found to be constitutional, health insurance will be extended by 2016 to thousands of CA's clients who are now 100% self-insured, but who will respond to the provision's economic incentive to obtain health insurance coverage by either enrolling in Medicaid (i.e., BadgerCare), obtaining individual policies from competing private health companies, or enrolling in their employers' health care programs (if their employers offer health insurance). Independent experts estimate that 340,000 uninsured individuals across Wisconsin will obtain coverage due to a combination of the ACA's minimum coverage provision, expanded Medicaid eligibility for those below 133% of FPL, and federal tax credits aimed at

inducing low-to-moderate income individuals to obtain health insurance. [6]

Upholding the ACA's minimum coverage provision will also benefit CA's low-income clients, Wisconsinites in general, and Americans who work—as well as the nation's small employers—by helping to shore up the law's new health insurance exchanges. The minimum coverage provision's clear economic incentive to obtain health insurance will encourage more working individuals above 133% of FPL and more small employers to use these exchanges. Those who do so will then gain (compared to now) a much wider choice of health care plans, regardless of health status, at normal

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[6] In 2016, implementation of the ACA in Wisconsin is estimated to reduce the number of uninsured from 520,000 to 180,000. This expansion in insurance coverage is attributable in part to the ACA's extension of Medicaid to currently uninsured individuals below 133% of FPL, but also to the operation of the minimum coverage provision's incentive to those between 133% and 400% of FPL to obtain coverage as well as the law's federal tax credits for members of the 133%-400% group who obtain coverage through a state health insurance exchange. Gorman Actuarial et al., *The Impact of the ACA on Wisconsin's Health Insurance Market*, 7 tbl.2 (July 18, 2011), http://www.freemarkethealthcare.wi.gov/section.asp?linkid=1748&locid=173 (prepared for the Wisconsin Department of Heath Services).

market-rate premiums. In addition, expanding the size of the pool of workers and small employers that enroll in the ACA's exchanges will strengthen the exchanges' capacity to trigger more intense market competition by the private insurance companies that bid on the exchange. Such enhanced competition will in turn help to hold down insurance costs for individuals and businesses alike, while enhancing the quality of health care.

On the other hand, the elimination of the law's minimum coverage provision (even if the law's Medicaid expansion is upheld) will mean that a large portion of low-income, uninsured CA clients, Wisconsin residents, and Americans will remain uninsured. Striking down the provision would also shrink the pool of participants that use health insurance exchanges, thus diminishing their potential to galvanize private market forces to constrain costs and improve quality.

SUMMARY OF THE ARGUMENT

The Affordable Care Act (ACA) is lengthy and complex, but it rests on a simple philosophy and just a few major building blocks.

Rejecting calls for a radical "socialized" approach to health insurance reform (such as a "single payer" program), Congress decided instead to preserve, but modify, the nation's three major health insurance institutions: Medicaid for the poor, the private health insurance market for the non-poor non-elderly, and Medicare for persons 65 and over. At the same time, Congress substantially modified all three to make sure that virtually every legal American resident obtains coverage, give small employers more and less costly insurance choices, and hold down insurance costs while advancing health care quality.

This case focuses on a challenge to the constitutionality of one the ACA's modifications of the current system—the minimum coverage provision, which provides a penalty for those who do not have health insurance coverage and thus creates a clear economic incentive for 100% self-insured

individuals to obtain coverage and stop using the majority of insured Americans and the nation's employers as their "excess liability carriers."

The respondents in No. 11-398 (Department of Health and Human Services, et al, v. Florida, et al.), with respect to the minimum coverage issue, argue that the penalty exceeds Congress' power to regulate the economy under the Commerce Clause.

In fact, the decision to go entirely without health insurance—to be 100% self-insured—is not "passive" non-economic conduct. Rather, it is an "active" economic decision. The decision imposes a major economic burden on the majority of insuring Americans, harms the nation's employers who provide health insurance, and undermines the ability of the U.S. economy to compete, sell products and services, and create jobs.

There is clear evidence that the choice made by the 100% self-insured harms others. An independent actuarial analysis by Milliman, Inc., indicates that the failure of over 40 million Americans to obtain health insurance shifts more than $42 billion in costs to insured Americans, imposing an extra $368 in annual insurance costs for individual coverage

and an extra $1,017 per year for family coverage. In essence, the 100% self-insured are using the rest of us, and America's employers, as their "excess liability carriers."

The choice made by the 100% self-insured to avoid insurance coverage also creates serious health and economic risks for those individuals. They are more likely to fail to get needed medical care for both children and adults. They are more likely, when they do get care, to be unable to pay the bill, lose their savings, and be hounded by bill collectors.

Just as the current crisis of over 40 million uninsured and over $42 billion in cost-shifting has profound economic effects, the ACA's policy of creating an incentive for the 100% self-insured to obtain health insurance, and to stop using insured Americans and insuring employers as their "excess liability carriers," will profoundly alter the U.S. economy as a whole. Those currently 100% self-insured will spend less on non-health commodities and services and more on health insurance. Those with insurance will spend more on non-health commodities and services, since the cost-shifting they now bear will diminish. The nation's employers

will also experience less cost-shifting, helping them to lower prices, sell more, and hire additional American workers.

The ACA's incentive to the 100% self-insured to obtain coverage, and to stop using the rest of us as their "excess liability carriers," will thus result in a major reallocation of economic activity within the U.S. Redirecting the flow of billions of health care dollars across such a vast swath of the American economic landscape, altering the purchasing patterns of almost every American, and strengthening the competitiveness of the nation's employers, is surely within Congress' authority under the Commerce Clause.

ARGUMENT

I. THE AFFORDABLE CARE ACT (ACA) MINIMUM COVERAGE PROVISION AIMS TO DETER THE 100% SELF-INSURED FROM CHOOSING TO SHIFT THEIR HEALTH CARE COSTS TO INSURED AMERICANS AND INSURING EMPLOYERS.

A. Individuals Who Refuse to Buy Health Insurance Are Not Engaged in "Passive" Non-Economic Inactivity. Rather, They Have Decided to Make an "Active" Economic Choice to 100% Self-Insure.

Virtually all Americans get sick or have an accident at some point.[7] As a result, we spend an

[7] The 2010 National Health Interview Survey found that 80% of American adults aged 18 years and over contacted or visited a doctor or other health professional in the previous year. The survey found that 66% had done so during the previous six

annual average of more than $8,000 for health care.[8] We pay for these costs through a combination of self-insurance[9] and insurance.[10]

We are all self-insured, in the sense that virtually all of us pay out-of-pocket for at least a portion of our health care costs.[11] But the self-

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months. *See* Jeannine S. Schiller et al., *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010*, 10 Vital and Health Statistics, 44 (Nov. 2011), http://www.cdc.gov/nchs/data/series/sr_10/sr10_252.pdf.

[8] The average annual per capital health expenditure was $8,086 in 2009. *See* Centers for Medicare & Medicaid Services, *National Health Expenditure Data: History*, https://www.cms.gov/NationalHealthExpendData/ 02_NationalHealthAccountsHistorical.asp#TopOfPage (last modified Nov. 4, 2011).

[9] Self-insurance is sometimes described as "self-pay." As used here, the phrase does not refer to the practice that many large employers have of paying directly for their employees' health care costs and, thus, functioning as their own insurance issuer.

[10] Health insurance is sometimes purchased by individuals directly from an insurance issuer; sometimes purchased on an individual's behalf from an insurance issuer by an employer or other entity (with, at times, the employee paying a portion of the cost, typically in the form of a pre-tax deduction from earnings); and sometimes provided to an individual by an employer or other entity that functions as the insurer (with, at times, the employee paying a portion of the cost), often with a third-party administrator handling payments made to health care providers.

[11] *E.g.*, in 2009, average out-of-pocket spending for health care exceeded $800, compared to an average annual per capita health expenditure of $8,086. *See* Centers for Medicare & Medicaid Services, *supra* note 8. According to CMS, "[O]ut of

insured can be divided into two major groups: (1) the minority who are 100% self-insured and attempt to pay out-of-pocket for the full amount of their health care costs, and (2) the majority of us who are partially self-insured, use our own funds to pay only for a limited share of our health care costs, and rely on health insurance to pay for the larger part of our health care costs.[12]

Americans do not simply "fall" by chance into either category. We *choose* whether to be 100% self-

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pocket spending in 2009 was $299.3 billion, or 12 percent of total national health expenditures." Centers for Medicare & Medicaid Services, *National Health Expenditure Data: NHE Fact Sheet*, https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp (last modified Nov. 4, 2011).

[12] In 2010, 49.9 million Americans, or 16.3% of the total U.S. population of 306.1 million, were uninsured for the entire year, i.e., 100% self-insured. The number of people with health insurance at some point during the year was 256.2 million, or 83.7% of the population. Carmen DeNavas-Walt et al., U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, 23-27 (Sept. 2011), http://www.census.gov/prod/2011pubs/p60-239.pdf. Private health insurance accounted for 35% of all health spending in 2007, and public programs, such as Medicaid, the State Children's Health Insurance Program (SCHIP), and Medicare, accounted for 46% of all health spending in 2007. Kaiser Family Foundation, *Heath Care Costs: A Primer*, (March 2009), http://www.kff.org/insurance/upload/7670_02.pdf.

insured. We *choose* how much we want to obtain insurance. We can alter that economic choice.[13]

Whatever choice Americans make with respect to the degree to which they self-insure—100% *vs*. partial (in combination with insurance)—it is a conscious choice.[14] It also is an economic choice—a decision about income, assets and risk. And those who make the choice to 100% self-insure are making economic decisions not only for themselves but also for their fellow Americans.

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[13] Those who are 100% self-insured can choose to become largely insured through three primary mechanisms: (1) enrolling in Medicaid if they have sufficiently low-incomes; (2) buying an individual health insurance policy, sacrificing other forms of consumption to pay the required premium; or (3) electing to join employer-sponsored insurance (ESI), typically reducing their earnings—and thus sacrificing other forms of consumption—in order to pay the employee's share of insurance coverage. Conversely, those who are partially self-insured but largely insured can choose to become 100% self-insured by dropping coverage. They can quit Medicaid though eligible; refuse to buy individual health insurance; and refuse to participate in ESI. They can, in the language of health insurance, "go bare." (The preceding discussion does not apply to those who have reached age 65. With rare exceptions, they are automatically insured through Medicare.)

[14] Obviously, children and some adults do not make this choice. They are bound by the choices of their parents or guardians.

B. When Individuals Become 100% Self-Insured, They Turn Insured Americans and Insuring Employers Into "Excess Liability Carriers" and Make Us Pay Over $42 Billion in Uncompensated Care Through Higher Premiums, Lower Living Standards, and Less Competitive Employers.

The 100% self-insured knowingly decide to retain more income, enabling them to buy more non-health products and services, when they choose to forego health insurance. By the same token, they knowingly decide to increase the odds that they will not be able to pay their bills if they incur significant health care costs. By making this economic trade-off, they have decided to shift the risk of their inability to pay their health care bills *from* themselves *to* the majority of their fellow citizens and to businesses that pay for insurance. In short, the 100% self-insured have made an economic decision to rely on the rest of us as their "excess liability carriers."

By contrast, the great majority of Americans, who annually elect to obtain health insurance, have

decided to diminish our disposable incomes—money we might have otherwise used for non-health necessities and other expenses—to pay for health insurance. We have opted to shrink our living standard to greatly increase the odds that we can pay our health care bills. We have thus acquiesced in shouldering the economic burden of being the 100% self-insured population's "excess liability carriers"—not because we desire to subsidize them, but because the interaction between the current U.S. health insurance system and our prudence creates an economic chain reaction that permits them to "ride free" on us and gives us no way out.

As Americans make (and remake every year) our health insurance choices, many are aware—and all can be held responsible for the fact—that our decisions have wider economic consequences. In particular, those who choose to be 100% self-insured can be held responsible for the fact that their decision to forego health insurance means that a large chunk of *their* health care costs will be paid for by *others* who have made the opposite choice, as well as by the nation's businesses that provide health insurance. The 100% self-insured may not enjoy the

label of "free riders." Few will understand the concept of "excess liability carrier." But some of the 100% self-insured will acknowledge—and all of them can be held accountable for the fact—that their conscious economic choices impose a true economic burden on everybody else.

It is a burden that can be named and quantified. Its name is "uncompensated care." Its cost is over $55 billion per year. The economic hardships it imposes are real and serious.

We fortunately live in a society where the health care system does not turn its back on the dying, the victims of accidents, and those struck down by dangerous illnesses. In the U.S., if you have a medical emergency and the ambulance rushes you to a hospital emergency room, the law requires that you must be treated regardless of income or insurance coverage.[15] In addition, hundreds of thousands of Americans who do not face a 9-1-1 type

[15] Emergency Medical Treatment and Labor Act, 42 U.S.C. §1395dd (2006). This Act ensures access to emergency services regardless of the patient's ability to pay for the services. Many hospitals would, of course, admit and treat such patients even if no legal requirement existed.

of emergency, but simply need hospitalization and medical care, receive treatment even though they lack the resources to pay the bill. Altogether, the "uncompensated care" received by 100% self-insured and inadequately insured Americans now annually exceeds $55 billion.[16]

The American system of providing so-called "uncompensated care" is far from perfect. It denies care at times to the 100% self-insured who need it; more frequently it delays their receipt of care or cuts them off prematurely. But self-insured Americans nonetheless receive an enormous amount of "uncompensated care" for which they do not pay.

But somebody else does pay. America's $55-plus billion in unpaid health care bills does not vanish into thin air. "Uncompensated care" is just a fancy expression for cost-shifting. Hospitals and doctors do not work for free. They try to collect most of the debts they are owed. When they cannot

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[16] The uninsured alone received approximately $56 billion in uncompensated care in 2008. *See* Jack Hadley et al., *Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs*, Health Affairs, 27, No.5, 2008. http://content.healthaffairs.org/content/27/5/w399.full.pdf.

induce the 100% self-insured to pay their bills,[17] health care providers shift most of the cost of the "uncompensated care" to their insured patients.

Insured patients thus finance a high portion of the 100% self-insured's health care costs *in addition to* their own health care costs. Insured patients provide this subsidy in part by paying deductibles, co-pays, and co-insurance amounts to hospitals, doctors, and other health care providers that exceed true cost. The largest portion of the subsidy that the 100% self-insured receive from insured patients, however, comes in the form of the higher insurance premiums or bills that insured patients and insuring employers must bear in excess of true cost.

Experts have documented the size of the cost-shift from the 100% self-insured to insured Americans and insuring employers—the

[17] Lack of income is often the reason why the 100% self-insured fail to pay their medical bills. Approximately one-third of the uninsured—16.2 million of the 49.9 million in 2010—had annual household incomes of less than $25,000. Roughly another third—15.4 million—had incomes between $25,000 and $50,000 that year. Thus, nearly two-thirds of the uninsured—31.6 million—had incomes below $50,000. *See* DeNavas-Walt, *supra* note 12, at 26 tbl.8.

"hydraulics" of the mechanism through which the 100% self-insured turn the rest of us their "excess liability carriers." Not all of the $55-plus billion in uncompensated care is shifted directly to insured Americans and insuring U.S. employers, but most of it is. According to a 2009 analysis by Milliman, Inc., an independent actuarial consulting firm, the portion of the 100% self-insureds' health care costs that neither they nor government programs pay for was $42.7 billion in 2008. The Milliman study concluded that this transfer of $42.7 billion from the 100% self-insured to insured individuals increased the health insurance costs of the insured population (excluding those covered by Medicaid and Medicare) by an annual average of $368 per insured individual person and $1,017 per insured family.[18]

This massive, $42.7 billion shift in costs from the 100% self-insured to the insured simultaneously harms not only insured individuals and the nation's employers, but also the competitiveness of the U.S. economy. Because the insured majority must absorb

[18] Kathleen Stoll et al., *Hidden Health Tax: Americans Pay a Premium*, Families USA, 17 (May 14, 2009).

an extra $368 per year for individual coverage and $1,017 for family coverage, the insured majority has less to spend for food, clothing, shelter, and other necessities. High school students who might continue go to college, as well as college students who might graduate, cannot do so because their parents' diminished incomes has made the cost of college tuition beyond reach. Workers who might otherwise be hired remain unemployed, and workers who hold jobs get laid off, as insuring employers cut labor costs to finance their excess insurance expenses. Finally, American businesses find they cannot sell their products and services—whether overseas or at home—because they are compelled to build the extra cost of health insurance into the prices of their products and services.

In short, the decision of the 100% self-insured to remain self-insured is not neutral. The choice they make inflicts economic pain on hundreds of millions of others. None of the self-insured may intend this to happen. Few even understand—at least fully—the harmful economic consequences. But the economic damage is real, and it is enduring.

C. The 100% Self-Insured Also Inflict Major Economic Harm On Themselves.

The decision of the 100% self-insured to forego insurance also exposes them to extremely serious health and economic hardship.

The 100% self-insured typically have low incomes and negligible assets. When combined with their lack of insurance coverage, their limited incomes and scant assets place them at severe risk for both poor health and economic trouble. The Kaiser Commission on Medicaid and the Uninsured reports that individuals below the poverty line comprise 40% of the uninsured, and nine out of ten uninsured are in low- or moderate-income families.[19] According to the Kaiser Commission:

> Half of uninsured households had $600 or less in total assets (not including their house and cars) in 2004, compared to

[19] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*, 5 (Washington: Kaiser Family Foundation, December 2010), http://www.kff.org/uninsured/upload/7451-06.pdf.

> median assets of $5,500 for insured households. Moreover, after households' debts are subtracted from assets, the median net worth of uninsured households drops to zero—leaving many of the uninsured with no financial reserves to pay unexpected medical bills.[20]

As a result, the 100% self-insured, with rare exception, cannot pay anything close to the full cost of a major illness or accident.

The most serious consequence is that the 100% self-insured—knowing they cannot pay—often fail to seek and receive the health care they need. They are far more likely than the insured to forego needed care. According to the Kaiser Commission: "Uninsured children with common childhood illnesses and injuries do not receive the same level of care as others. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions."[21]

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[20] *Id.* at 13.
[21] *Id.* at 10.

The Kaiser Commission reports similar problems for adults:

> About one-quarter of uninsured adults say that they have forgone care in the past year because of its cost—compared to 4% of adults with private coverage. …. More than a quarter of uninsured adults say they did not fill a drug prescription in the past year because they could not afford it. ... Uninsured nonelderly adults, compared to those with coverage, are far less likely to have had regular preventive care, including cancer screenings. Consequently, uninsured patients are diagnosed in later stages of diseases, including cancer, and die earlier than those with insurance.[22]

The 100% self-insured, when they do obtain medical care, also face far more severe financial stress and crises than the insured. According to the Kaiser Commission: "Uninsured adults are three times as likely as the insured to have been unable to

[22] *Id.* at 10-11.

pay for basic necessities such as housing or food due to medical bills. Medical bills may also force uninsured adults to exhaust their savings."[23] In 2010, 27% of uninsured adults used up all or most of their savings paying medical bills, compared to 7% of the insured. The same year, 33% of the uninsured were contacted by a collection agency about medical bills, compared to 8% of the insured.[24]

While some of the 100% self-insured may be lucky enough to avoid accidents or injuries in any year, their choice is a huge economic gamble. The decision can equally result in devastating economic consequences for children, adults, and entire families—eviction, repossession, homelessness, malnutrition, and destitution—if the bet does not pay.

Thus, the decision to become 100% self-insured has profound consequences across the economic board. It puts at risk and frequently harms the 100% self-insured themselves *at the same time* that it shifts over $42 billion in unpaid medical

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[23] *Id.* at 12.
[24] *Id.*

bills to insured Americans and insuring employers. It temporarily raises the living standard of those who win the "non-insurance bet," while lowering the living standards of the insured and making U.S. employers less competitive and consequently less able to create jobs.

II. THE ACA POLICY OF CREATING AN ECONOMIC INCENTIVE FOR THE 100% SELF-INSURED TO OBTAIN HEALTH INSURANCE IS A VALID EXERCISE OF POWER UNDER THE COMMERCE CLAUSE.

The ACA creates an economic incentive for the overwhelming majority of Americans who are "applicable individuals" to obtain "minimal essential coverage." It does so by subjecting the members of this vast group to an "individual responsibility requirement" in the form of a "shared responsibility payment."[25] The law then provides that any

[25] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(a)-(b), 124 Stat. 119, 242-44 (2010) (as amended) (citing the Patient Protection and Affordable Care Act since

"applicable individual who fails to meet the requirement" must pay a "penalty," in an amount specified in the law, as part of the individual's federal income tax return.[26]

It is clear from the history and structure of the ACA that the sole purpose and actual function of this penalty is to offer an incentive to the 100% self-insured to obtain health insurance coverage.

Unlike all major taxes (and most minor ones), the goal of the ACA's penalty is not to raise revenue for government. Indeed, by definition, the *less* revenue the provision produces, the *more* Americans have obtained health insurance and thus maximized the ACA's goal of near-universal coverage.

Also unlike most taxes, which do not seek to discourage the economic activity that generates tax revenue, the ACA's penalty was put in place precisely to deter individuals from making the economic decision that triggers payments to

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the Affordable Care Act has not yet been fully codified in the United States Code).

[26] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501 (b).

government. Federal, state, and local taxes—whether imposed on income, sales, and property—are neither intended to dissuade, nor in general do dissuade, people from making the wide range of economic decisions that yield tax revenues (such as earning money, buying products, investing in stocks, making corporate profits, or acquiring or improving property). The ACA's penalty is the exact opposite in intent and effect. It explicitly aims to dissuade 100% self-insured Americans from continuing their choice to go without health insurance. It means to drive them away from the very decision that would yield revenue for the federal government.

Finally, unlike many other fines and other penalties, which truly seek to punish wrongdoers who engage in dangerous or obnoxious behavior (like running a red light, or tossing garbage out of the car window, or setting off fireworks in a city neighborhood at 3 AM) as much as they intend to encourage socially responsible conduct, the ACA provision does not treat the 100% self-insured as social malefactors. Their choices indeed do impose economic burdens on others, as well as create big health and economic risks—and frequent

consequences—for themselves. Some of them may know this; all can be held accountable for knowing this. But the national debate over the ACA did not treat the 100% self-insured as wrongdoers, but typically viewed them as beleaguered fellow-citizens who have chosen to cut economic corners in their struggle to get by, and should be simultaneously nudged by an incentive and helped by subsidies to go in a different direction

The purpose and function of the ACA's penalty is thus clear: *not* to raise tax revenues, *not* to discourage virtuous economic activities that spin off taxes, and *not* to inflict punishment, but to create an economic incentive (linked to substantial subsidies) that induce the 100% self-insured to join the vast majority of Americans and obtain health insurance coverage via either Medicaid, an individual policy, or employer-sponsored insurance. Congress' intent was never to trigger the penalty, but simply to stop the 100% self-insured from using the insured majority and the nation's struggling employers as their "excess liability carriers."

One economic side-effect of this incentive is that Congress also created an incentive for a large

portion of the 100% self-insured group—those not qualifying for Medicaid because their incomes exceed 133% of FPL, and who must therefore spend some of their own money to obtain health insurance—to *reduce* their consumption of non-health products and services.[27] This reduction in consumption will mirror an *increase* in the consumption of non-health products and services by those who are currently insured, but whose future premium costs will absorb far less of today's $42-plus billion cost shift. The ACA will thus greatly alter consumption patterns within the U.S. economy.

Whether Congress acted wisely to alter these consumption patterns is of course a matter of debate. What is beyond debate is that Congress's

[27] For the poorest of the 100% self-insured, it is unlikely that they will need to reduce their consumption of food, clothing, shelter, etc., in order to join Medicaid, since Medicaid typically charges no premiums, and imposes either no or extremely low deductibles and co-pays. For the remainder of the 100% self-insured, however, including those who qualify for federal tax credits if their income is between 133% and 400% of the poverty line, it will be necessary to spend less on non-health products and services in order to pay for a portion of their health insurance premiums, and also to pay for the deductibles, co-pays, and co-insurance that their health insurance plans are likely to require.

creation of an incentive that encourages the 15% of Americans who are 100% self-insured to make different economic choices, counteracts the shift of over $42 billion in uncompensated care to the insuring majority and the nation's insuring employers, and thus shrinks the role that the insured play as "excess liability carriers," will have profound economic effects across the country.

The ACA's policy will also increase utilization of doctors, prescription drugs, and hospitals by those who need care; protect families' savings; and decrease bankruptcies. The policy will enable more American workers to find a job and keep a job, by allowing insuring U.S. businesses—no longer the victims of a massive health cost shift—to hold down the prices of their products in an increasingly price-sensitive international marketplace. And, across the broad economic landscape of the nation, it will alter patterns of consumption of non-health items.

Because the ACA's penalty provision was designed to propel—and surely will propel—so many large economic waves to reshape both the health sector and non-health sector of the American economy, it is a legitimate exercise of Congress'

power to regulate the economy under the Commerce Clause.

Consider two reference points. Congress acted within the scope of the Commerce Clause in regulating a Kansas farm household that consumed all of its own wheat,[28] and in regulating a Californian who grew a few marijuana plants for personal consumption.[29] That so, it is hard to conceive how a law intended to alter a major purchasing decision made each year by millions of Americans, designed to counteract a $42.9 billion cost shift, and calculated to profoundly reshape the flow of billions of dollars and rearrange consumption patterns within a vast swath of the nation's economy, could be outside Congressional power.

The ACA's incentive "exerts a substantial economic effect on interstate commerce" and on international commerce as well.[30] It is constitutional.

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[28] *Wickard v. Filburn*, 317 U.S. 111 (1942).
[29] *Gonzales v. Raich,* 545 U.S. 1 (2005).
[30] *Wickard*, 317 U.S. at 125.

III. CONCLUSION: CONGRESS' POLICY OF MOTIVATING THE 100% SELF-INSURED TO OBTAIN HEALTH INSURANCE IS A CONSTITUTIONALLY VALID MEANS TO ACHIEVING LEGITIMATE ENDS—FAIRER PAYMENT OF MEDICAL COSTS, IMPROVED HEALTH OUTCOMES, AND ECONOMIC RELIEF FOR THE NATION'S SELF-INSURED, INSURED, AND EMPLOYERS.

The ACA's minimum coverage requirement is not about raising revenue, nor is it about punishing wrongdoers. The provision has a simpler premise and a different purpose.

Its premise is that the 100% self-insured make an explicit economic decision when they choose not to obtain health insurance coverage, and that this decision (whether the 100% self-insured knowingly or intentionally wish for the result) imposes an unfair $42 billion economic burden on the majority of Americans and the nation's employers in the form of higher insurance costs.

The minimum coverage provision's purpose is equally simple: to create an incentive for the 100%

self-insured to obtain health insurance, to reverse a large part of the $42 billion cost shift and unburden the majority of Americans who have insurance, and to lower the cost of doing business—and increase the competitiveness—of U.S. employers.

The nation and Congress have debated with heightened intensity the merits of the provision. The question, however, is whether Congress' decision to impose a penalty on the 100% self-insured in order to give them an incentive to buy insurance, and to dissuade them from using the majority of insuring Americans and our employers as their "excess liability carriers," is valid under the Commerce Clause.

The minimum coverage provision, because of its massive and multi-dimensional impact on the U.S. economy and foreign commerce as well, lies well within the realm of Congress' authority under the Commerce Clause. It should be upheld.

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