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.

On Writ Of Certiorari To The United States Court of Appeals For The Eleventh Circuit

AMICUS BRIEF OF THE GOVERNOR OF WASHINGTON CHRISTINE GREGOIRE IN SUPPORT OF PETITIONERS (MINIMUM COVERAGE PROVISION)

KRISTIN HOUSER*
ADAM J. BERGER
REBECCA J. ROE
WILLIAM RUTZICK
SCHROETER, GOLDMARK & BENDER
810 Third Avenue, Suite 500
Seattle, Washington 98104
Telephone: (206) 622-8000
E-Mail: houser@sgb-law.com

Counsel for Amicus Curiae
**Counsel of Record*

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I. INTEREST OF AMICUS CURIAE[1]

The Governor of Washington, Christine Gregoire, is the chief executive officer of her State, and she is responsible for the administration and budgeting of the numerous state health care programs and initiatives affected by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "ACA," or the "Act"). Governor Gregoire supports the reforms embodied in the Act and believes the minimum coverage provision is an appropriate use of federal power under the Interstate Commerce Clause to achieve a more rational system of paying for the consumption of health care, in particular by individuals who are now uninsured. For years, the State has grappled with the problem of increasing health care costs for State residents, clients of State agencies, and public employees. Rising health care costs also threaten the economic vitality of the State, which relies not only on interstate commerce, but also heavily on international trade. Given the immense scope of the problem and the interstate nature of the health insurance and health care markets, the Governor sought federal assistance in crafting a broader, more effective solution than states would be able to implement on their own. The Governor participated in the political process that led to passage of the Act and believes it is a reasonable and necessary response to these shared state and federal goals.

[1] Written consents from all parties to the filing of amicus curiae briefs are on file with the Clerk. Counsel for amicus represents that it entirely authored this brief and no party, its counsel, or any other entity but amicus and its counsel made a monetary contribution to fund the brief's preparation or submission.

II. SUMMARY OF ARGUMENT

The Governor of Washington believes that the minimum coverage provision of the ACA is a constitutional exercise of Congress's power under the Commerce Clause to regulate the interstate market in health care and insurance. Washington's experience with implementing health insurance reforms such as those in the ACA directly refutes the majority opinion in the court below that Congress could not reasonably find that the minimum coverage provision was a reasonable and necessary adjunct to health insurance reform. In Washington, similar reforms without universal coverage led only to a death spiral in the individual insurance market. Without the insurance reforms contained in the ACA, and specifically, the minimum coverage provision, Washington will continue to suffer the effects of an inequitable and irrational system of providing and paying for the health care of the uninsured, a system that is national in scope and can only be reformed at the national level. As home to a leading regional trauma center, Washington also has experience with the phenomenon of interstate travel by the uninsured to obtain medical care and the financial burdens this places on the economy and institutions of the State. Finally, in Washington, promising efforts are underway to reform the delivery of health care so as to improve the health of consumers and lower the cost of their care; broad access to affordable insurance, which will only be possible with the minimum coverage provision of the ACA, is critical to the success of these efforts. It is on the strength of these experiences in Washington that the Governor supports the Act's minimum coverage provision and concurs in its constitutionality.

III. WASHINGTON'S BUDGET AND ECONOMY HAVE SUFFERED FROM SPIRALING HEALTH CARE AND INSURANCE COSTS AND THE COSTS OF CARING FOR THE UNINSURED

The state agencies for which the Governor is responsible are major purchasers of both health care and health insurance, including programs that provide insurance, services, or prescription drugs to low-income adults, a large percentage of children in the state, state employees, and injured workers. As a result, the State's budget has been severely impacted by the spiraling costs of services and insurance and declining access to affordable care. In recent years, health-related costs have accounted for up to one-third of the State's general spending.[2]

Despite these expenditures, the State has suffered significant difficulties in meeting the health care needs of its citizens. The scope of the unmet need is illustrated by the State's Basic Health program, which provides subsidized coverage for low-income, childless adults who typically do not qualify for Medicaid. Approximately 160,000 citizens who want to access Basic Health coverage cannot, due to State budget constraints.[3] Studies project that shortfalls in state programs to cover the uninsured such as Basic Health would only worsen in the absence of national health care reform.[4]

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[2] Washington Alliance for a Competitive Economy, Competitiveness Br. 08-03, *The Healthcare Spending Squeeze* (July 28, 2008) (www.researchcouncil.org/docs/PDF/WASHACEBusinessClimate/TheHCSpendingSqueeze.pdf).

[3] Budget shortfalls have forced the Governor to propose elimination of this program several times. In response, the Legislature moved to reduce enrollment, most recently by 17,000. Further reductions, or complete elimination, will only exacerbate the problem of the uninsured in Washington and the need for a federal solution.

[4] Garrett, *et al*., Urban Institute, *The Cost of Failure to Enact Health Reform: 2010-2020* (Mar. 2010), at 2 (http://www.rwjf.org/files/research/49148.pdf).

The high cost of health insurance, resulting in part from cost-shifting to pay for care for the uninsured, has also hampered economic growth in the State and the ability to participate effectively in interstate and international commerce. A recent report by Washington's Insurance Commissioner estimates that each insured family in Washington pays an additional $1,017 per year in medical bills to help cover the costs of the uninsured, compared to $917 last year.[5] This figure has been steadily rising as the proportion of the population without insurance increases. By the end of 2011, 14.5% of Washingtonians were projected to be uninsured, up from 12% just two years ago.[6] Among working-age adults, the figure is 19.7%.[7] The situation has deteriorated even faster in rural areas of the state, with the percentage of uninsured exceeding 20% in five rural Washington counties in 2010.[8] But for the fact that baby boomers are reaching the age of Medicare eligibility and that many students are now covered on their parents' plans as a result of the ACA, these number would be even higher.[9] Likewise, the cost of charity care in Washington rose a staggering 36% from 2008 to 2010, largely due to the increase in the uninsured population.[10]

As an inevitable result, the cost to businesses of employee health benefits has risen apace: premiums rose 42% for individuals and 54% for families between 2003 and

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[5] Washington State Office of the Insurance Commissioner, *State of the Uninsured: Health Coverage in Washington State* (December, 13. 2011) (http://www.insurance.wa.gov/legislative/uninsured-washington.shtml) ("2011 OIC Report"); Washington State Office of the Insurance Commissioner, *A Problem We Can't Ignore: The Hidden and Rapidly Growing Costs of the Uninsured and Underinsured in Washington State* (Nov. 2009), at 3 (http://www.insurance.wa.gov/publications/agency_reports.shtml) ("2009 OIC Report").

[6] 2011 OIC Report, at 1.

[7] U.S. Census Bureau, 2010 American Community Survey, 1-Year Estimates Selected Characteristics of the Uninsured in the United States, Washington Table (www.census.gov/acs/www/).

[8] 2011 OIC Report, at 3.

[9] *Id.* at 4.

[10] *Id.* at 1.

2010, far outstripping the overall inflation rate of 18.5% for that same time period.[11] In states like Washington, where more than 20% of jobs derive from international trade, these increases cause grave concern that businesses will be increasingly unable to compete in the international economy.[12] For example, Washington's closest competitors and trading partners include Canada and Japan.[13] Both have *per capita* expenditures on health care 55% or less than those borne by businesses and workers in the United States.[14] Similarly, America's *per capita* health care costs range between 89% and 128% higher than costs in the European countries where Airbus, the main competitor of Washington's largest exporter, Boeing, has its manufacturing plants.[15]

Uncontrolled health care costs, in part due to the high cost of uncompensated care, have stifled the growth of small businesses, created a disincentive for hiring new employees, and dramatically reduced the availability of affordable insurance through employer group plans. Increasing numbers of small employers in Washington have dropped health care coverage for their employees or have increased their employees'

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[11] Squires, The Commonwealth Fund, *State Trends in Premiums & Deductibles, 2003-2010:The Need for Action to Address Rising Costs.* (November 2011), at 18 (http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Nov/State%20Trends/1561_Schoen_state_trends_premiums_deductibles_2003_2010.pdf).

[12] Business Round Table, *Trade Creates Jobs for Washington* (January 1, 2010) (http://businessroundtable.org/studies-and-reports/trade-creates-jobs-for-washington/), http://www.oecd.org/dataoecd/46/2/38980580.pdf.

[13] *Id.*

[14] Organization for Economic Cooperation & Development, *OECD Health Data 2011: How Does the United States Compare* (http://www.oecd.org/dataoecd/46/2/38980580.pdf).

[15] *Id.*

share of health care costs as a result of unpredictable rate spikes in the small group markets.[16]

Finally, the State has directly suffered from the high cost of uncompensated care caused by the lack of affordable insurance for large portions of its citizenry. The problem of the uninsured has impacted the State budget and economy in numerous ways, including: the shifting of costs through increased premiums paid by the State as an employer and increased charges paid by the State for the care of disabled workers; subsidization by the State of hospitals providing uncompensated care, including to uninsured patients from other states; the huge cost of long-term care for the many disabled and elderly who are uninsured for this form of care; and the lost productivity of workers due to preventable illness and disability.

IV. THE GOVERNOR SOUGHT THE ACT AS A NECESSARY FEDERAL RESPONSE TO AN INTRACTABLE NATIONAL PROBLEM

Because of the severe challenges to the State's budget and economy, the Governor welcomed a federal solution that would expand coverage, including to many whose health care has been wholly funded by the states, and increase competition and affordability in the insurance market. Governor Gregoire also advocated federal action to reform the nation's health care system with a focus on delivery models that would provide less costly care and lead to better outcomes through, *inter alia*, making disease prevention and chronic disease management more accessible to low-income individuals. The Act is a product of the political dynamic in the federal system, in which Congress

[16] 2009 OIC Report, at 4; Washington State Employment Security Department, *2010 Washington State Employee Benefits Survey* (August 2011), at 6-8 (https://fortress.wa.gov/esd/employmentdata/docs/occupational-reports/2010-employee-benefits-report.pdf).

properly moved to address a problem that proved beyond the reach of the states alone, building upon the previous efforts of the states as "laboratories for social and economic experiment." *Garcia v. San Antonio Metro. Trans. Auth.*, 469 U.S. 528, 546 (1985). In short, this is a national rather than a local problem, which falls well within the parameters of the Interstate Commerce Clause. *See Wickard v. Filburn*, 317 U.S. 111 (1942).

For years, the Governor pursued state-level initiatives to address these issues. Her Blue Ribbon Commission on Health Care Costs and Access led to a number of major initiatives, including using the State's purchasing power to support development of the "medical home" model of coordinated care, as well as financial incentives based on improved health outcomes, rather than on the number of procedures performed.[17] The State also has its Basic Health program, whose purpose is to offer affordable health coverage to low-income Washington residents. *See* RCW 43.06.155. These efforts, while significant, informed the Governor's recognition that implementation of reform on a national level was necessary to realize their full benefits.

In fact, many ACA provisions parallel and complement aspects of state programs and initiatives, including in the areas of care coordination, insurance market reforms, and expansion of publicly funded care to childless, low-income adults. The Act builds on the experiences of the states, such as Massachusetts' experiment (under a Medicaid waiver) with universal coverage. As a further example, the Act creates incentives for states to "rebalance" their Medicaid long-term care systems away from institutional care to home and community-based settings, where appropriate. *See* 42 U.S.C. § 1396n(k). This

[17] Washington State Blue Ribbon Commission On Health Care Costs And Access (January 2007), at 5 (http://www.leg.wa.gov/JointCommittees/HCCA/Documents/Final%20Report.pdf).

provision was based on Washington's experience with such rebalancing.[18] The policy choices embodied in the Act, including the provisions on universal coverage and funding for developing less costly, more effective models of care, were the result of a political process in which the states and their citizens had ample opportunity to be heard and in which the role of the states as laboratories for innovation was honored.

V. THE MINIMUM COVERAGE PROVISION IS A NECESSARY AND PROPER EXERCISE OF FEDERAL POWER UNDER THE COMMERCE CLAUSE TO ADDRESS INTERSTATE ECONOMIC PROBLEMS, INCLUDING THE COSTS OF THE UNINSURED, THAT CANNOT BE SOLVED BY STATES ACTING ALONE

The Governor supports the minimum coverage provision of the ACA, and believes that provision directly serves federalism by protecting her State from costs that otherwise would be imposed on Washington's budget and health care system, not just by its own uninsured, but by uninsured residents of other states seeking care in Washington facilities. The Governor further believes that actions of the uninsured with significant economic costs – such as accessing care late in the course of a disease, at more expensive levels of care, because of the unavailability of primary care, or at state-funded trauma centers when they suffer injury from unpredictable catastrophic events – must be addressed by a federal regulatory scheme that rationalizes payment and aligns incentives with less expensive, more effective care. As Washington's experience shows, the minimum coverage provision is essential to the success of that scheme.

[18] Press Release of Senator Cantwell (June 12, 2009) (http://cantwell.senate.gov/news/record.cfm?id=314410).

A. Washington Experienced A Death Spiral In Its Individual Insurance Market When It Enacted Reforms Without A Minimum Coverage Provision, Underscoring The Need For The Provision In The ACA.

The Governor's support of the ACA is informed by Washington's attempt to implement insurance reforms in the absence of minimum required coverage. Washington actually experienced the "death spiral" that can occur in the private insurance market when coverage for preexisting conditions is required without universal coverage. In 1993, the State adopted regulations governing individual health plans that prohibited denying enrollment because of health status and limited waiting periods for new enrollees to three months. *See* 1993 Wash. Laws Ch. 492, §§ 283-286; Wash. Admin. Code 284-10-050 (July 1, 1994). Within a few years, insurance carriers began reporting significant market losses and premiums began to rise. As in other states that attempted similar reforms, the major carriers in Washington stopped selling individual plans, leading to the virtual destruction of the individual insurance market.[19]

In 2000, the legislature was forced to restructure underwriting for the private market: preexisting condition waiting periods were extended, and insurers were allowed to screen out the most costly individuals. 2000 Wash. Laws. Ch. 79.[20] The State revived its dormant high-risk pool to provide those individuals with coverage. In making these changes, the legislature specifically identified the problem of eliminating barriers to access without requiring universal participation:

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[19] Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, Journal of Health Politics, Policy and Law 25(1): 133, 138-47 (Feb. 2000).

[20] *See also* Washington Research Council, Policy Brief 00-2 (May 15, 2000), at 3-4 (www.researchcouncil.org/docs/PDF/WRCBusinessClimate/SomeGains4Bus2000.pdf).

> *Generally, as rates increase without incentives for healthy people to maintain continuous coverage, the possibility exists that adverse selection will occur,* where healthy people who least expect to need expensive care choose not to have health coverage, or choose to enter the market only when needing major medical care and dropping coverage after receiving medical treatment.

Washington Senate Bill Rep. E2SSB 6067, 56th Leg. (2000) ("WSB Rep. 6067") (emphasis added).

In overturning Congress's decision to adopt the minimum coverage requirement, the Eleventh Circuit relied heavily on research by certain economists purportedly showing that the requirement is not necessary for insurance reforms to work. *Florida v. Department of Health and Human Services*, 648 F.3d 1235, 1299 (11th Cir. 2011). Thus, went the reasoning of that Court, deference should not be granted to Congressional findings that the minimum coverage requirement is an important component of overall reform of the health insurance market; in the Eleventh Circuit's judgment, the link between that provision and the desired goal, a more rational payment system for health care in this country, is too attenuated for it to be a valid exercise of Congress's powers under the Commerce Clause. *Id.* at 1300-02.

However, the reality of Washington's experience – as opposed to abstract projections by those engaged in the "dismal science" of economics – directly supports Congress's finding that the ACA's minimum coverage provision is a necessary and proper adjunct to other reforms of the insurance market. Interestingly, in dismissing the need for an individual mandate as part of the remedy for cost shifting by the uninsured, the Eleventh Circuit pointed to the ACA's prohibition of coverage denials to people with pre-existing conditions as taking care of a significant portion of the problem. *Id.* at 1299.

However, this is precisely what did *not* work in Washington: enabling those with pre-existing conditions to have access to health insurance in the absence of a requirement that healthy individuals participate in the insurance risk-sharing pool. The Eleventh Circuit ignores the risk of the insurance death spiral that can – and in Washington did – result from such an approach, but Congress did not. It reasonably concluded that, without universal coverage, other reforms that are intended to rationalize the market and increase access to affordable insurance for all Americans will instead have the opposite effect. The ACA thus builds on the experiences of Washington and other states to avoid the consequences that doomed individual state reform initiatives.

B. The Uninsured Are Born, Get Sick or Injured, And Use The Health Care Market: The Cost Of Their Care Significantly Burdens The State And Its Citizens.

Plaintiffs have portrayed the minimum coverage provision as forcing activity on citizens who choose to stay out of the marketplace. However, as Congress reasonably concluded, the need for health care at some stage of life is an almost universal condition of existence and is often unpredictable.[21]

[21] The Governor agrees with the appellants that the choice of how to pay for health care is not "inactivity." However, even if it were considered inactivity, the Governor does not believe that the federal government inherently lacks power to regulate "inactivity" when necessary for the health and safety of the nation. For example, if a nationwide pandemic were causing disruption of interstate commerce, like the Spanish flu of 1918, which each state lacked the capacity to address on its own, Congress would have authority under the Interstate Commerce Clause to impose such measures as vaccination and screening on a national basis. *See* 42 U.S.C. § 264; 42 C.F.R. 70.2 ("Whenever the Director of the Centers for Disease Control and Prevention determines that the measures taken by health authorities of any State or possession ... are insufficient to prevent the spread of any of the communicable diseases from such State or possession to any other State or possession, he/she may take such measures to prevent such spread of the diseases as he/she deems reasonably necessary...."); *see generally*, Hall, *Constitutional Mortality: Precedential Effects of Striking the Individual Mandate*, Wake Forest Univ. Legal Studies Paper No. 1959612 (Nov. 14, 2011). Penalties for noncompliance in such a situation would likely far exceed the fine that is the only consequence of refusing to buy insurance under the Act.

At the outset of life, 98.9% of all births in the United States take place in a hospital.[22] Thus, virtually every citizen of every state, including Washington, starts out as a consumer of health care. At the other end of life, people are living longer with chronic conditions that typically result in the utilization of health care resources.[23] For example, 91.5% of the population 65 and over has been diagnosed with a chronic condition such as diabetes, hypertension, or cancer.[24] Based on 2007 national data, only 6% of all individuals over 65 avoided a visit to a doctor's office in the previous twelve months.[25] Given these rates of consumption at the beginning and end of life, it is clear that almost no one is exempt from participation in the health care market.

The Governor has a legitimate concern regarding how and when such acts of consumption are paid for, particularly for the uninsured portion of the population. When lack of coverage results in inadequate care, she also has a significant concern about the resulting future consumption of costly health care resources. For example, uninsured children with serious health conditions, such as asthma and diabetes, that are not timely diagnosed or who do not have continuous medical coverage are more likely to incur avoidable hospitalizations.[26] Adults who delay care for chronic conditions such as high

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[22] Martin, *et al.*, Centers for Disease Control & Prevention, *Births: Final Data for 2009*, National Vital Statistics Reports 60(1):13 (Nov. 2011) (http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01.pdf).
[23] Lorenz, *et al.*, Agency for Healthcare Research & Quality, *End-of-Life Care & Outcomes: Summary*, Evidence Report/Technology Assessment No. 110 (Nov. 2004), at 1 (www.ahrq.gov/clinic/epcsums/eolsum.pdf).
[24] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey, Statistical Brief # 203.*
[25] http://hscdataonline.s-3.com/hhsurvey.asp.
[26] Institute of Medicine, *America's Uninsured Crisis: Consequences for Health and Health Care* (2009), at 71 ("IOM Report"); Bindman *et al., Medicaid Re-Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions*, 46 Medical Care 1049, 1052-54 (2008).

blood pressure are at higher risk of developing strokes requiring lengthy hospital stays.[27] Thus, the decisions of individuals about how to finance health care coverage for themselves and their families and when to access services can have profound impacts on the overall costs of care that affect price, demand, and supply across the market.

Moreover, while plaintiffs characterize this as a matter of freedom, or choice, the use of health care resources by the uninsured often is not subject to individual control. Children's health is significantly affected by lack of insurance,[28] yet children have no control over their insurance status. Further, the need for critical health care is frequently unplanned. There are, for example, unplanned births to uninsured individuals. Studies have found that poor birth outcomes are significantly higher in newborns with no insurance than those with private insurance, often leading to long, costly hospital stays and untold suffering by the children and families affected.[29] People do not plan to get cancer; when they do, the cost of chemotherapeutic drugs can be very substantial.[30]

Perhaps the most dramatic examples of unplanned use of health care resources result from automobile crashes, gunshot wounds, falls, and other catastrophic events. Severely injured victims may be unconscious and unable to make decisions, yet trauma research demonstrates that care within the first hour is critical to survival and recovery.[31] Plaintiffs, including the Attorney General of Washington, do not explain what they would

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[27] Shen & Washington, *Disparities in Outcomes Among Patients With Stroke Associated With Insurance Status*, 38 Stroke 1010-1016 (2007).
[28] IOM Report, at 58-63.
[29] Braveman, *et al*., *Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982-1986*, 321 NEJM 503-13 (1989).
[30] Meropol, *et al*., *Cost of Cancer Care: Issues and Implication*s, 25 J. Clin. Oncol. 180, 182 (2007).
[31] National Foundation for Trauma Care, *Trauma's Golden Hour* (http://www.traumafoundation.org/restricted/tinymce/jscripts/tiny_mce/plugins/filemanager/files/About%20Trauma%20Care_Golden%20Hour.pdf).

have trauma centers do when the voluntarily uninsured present as trauma victims; would they advocate refusing treatment because such individuals made the decision not to buy insurance? Or would they advocate that everyone else pay for the medical care that these people need but do not have the funds or insurance coverage to pay for? While plaintiffs might not expressly advocate for this kind of re-distribution of income, that is currently how the system works and will continue to operate if the pre-Act status quo is reinstated.

Turning away people who are suffering and can be helped is contrary to our societal values. Indeed, federal law prohibits such a response. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide sufficient treatment to stabilize all patients who present at their emergency departments with an emergency medical condition, or transfer them to a facility that can do so, regardless of insurance status. 42 U.S.C. § 1395dd (b)(1). The ACA specifically retains this requirement. *See* 42 U.S.C. § 1303(c).

Like other Level I trauma centers, Harborview Medical Center, the Level I center in Washington, takes all trauma patients transferred to it regardless of insurance status or ability to pay.[32] State and federal funding covers a portion of the cost of care for the 18% of trauma patients who are uninsured – but not all.[33] The Governor urged passage of the ACA in part because she supports the more rational system of funding trauma care that would result if most patients were insured.

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[32] National Foundation for Trauma Care, *U.S. Trauma Center Crisis* (May 2004), at 9 (www.traumafoundation.org/publications.htm). Level I centers provide the highest level of trauma care.

[33] *Id.* at 4 (reporting that only 8% of costs of caring for the uninsured are recovered).

The per-patient cost for care in a trauma center is $14,896.[34] Figures for Washington's Level I center indicate that claims paid by the State for trauma care for the most severely injured are frequently in the $50,000 to $125,000 range, or higher.[35] It was reasonable for Congress to infer that individuals who choose not to purchase minimum coverage, especially on the basis of alleged economic hardship, would not be able to afford the cost of such unexpected care.[36] Under the pre-ACA system, if uninsured individuals are in a car accident, develop cancer, or have a serious fall or a stroke, they receive care, *i.e.*, consume medical goods and services, and society pays what they cannot. In other words, those individuals, whose "freedom" plaintiffs seek to protect, are receiving a benefit – maintenance of an acute care system that is available to all – but are unwilling to pay their fair share of the cost of that benefit. They are getting "something for nothing" and the rest of society subsidizes them.

The high cost of such unpredictable, catastrophic events demonstrates the flaw in the Eleventh Circuit's second-guessing of Congress's factual findings. While the majority expressed concern that the minimum coverage requirement will be imposed on the healthy uninsured, who, in its view, are not contributing to the problem of health care costs being shifted to the insured, in fact, even healthy individuals are only one trauma or cancer diagnosis away from being cost-shifters themselves. *Florida v. Department of*

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[34] *Id.*

[35] http://hrsa.dshs.wa.gov/HospitalPymt/Trauma/RateFiles/TraumaClaims/1stQtr2011ClaimsDetail.pdf.

[36] Truly low-income persons are excluded under 26 U.S.C. § 5000A from tax penalties for failing to procure minimum essential coverage. For others, the cost of coverage pales in comparison to the potential cost for trauma care. *See* Chaikind, *et al.*, Congressional Research Service, *Private Health Insurance Provisions in PPACA (P.L. 111-148)*, CRS Rep. R40942 (Apr. 15, 2010), at 22 (calculating that the maximum annual out-of-pocket premium for qualifying coverage for a family of four at 400% of the Federal Poverty Level would be $8,379).

Health and Human Services, 648 F.3d at 1299-1300. For example, a thirty-five year old uninsured, employed male may be perfectly healthy at the time he gets on a motorcycle, but require massive intervention from a trauma hospital moments later. Such an individual quite likely could have afforded insurance premiums, but cannot afford the tens or hundreds of thousands of dollars of medical costs resulting from his severe injuries. What the Eleventh Circuit ignores is the moral hazard created by the elimination of the pre-existing condition exclusion and other barriers to access. The minimum coverage requirement provides the incentive for such healthy individuals to make the investment in their own health care security.

Congress certainly reasonably could have found that continuation of the current system of payment for the care of such individuals would increase health care costs and interfere with the viability of health insurance, which are part of interstate commerce. *See* 42 U.S.C. § 18091(a)(2)(H)-(J). Thus, it was well within Congress's constitutional authority to enact penalties in order to change the economic behavior of the healthy uninsured who do have sufficient income to purchase insurance, thereby alleviating the burden on interstate commerce resulting from their failure to do so. *Gonzales v. Raich*, 545 U.S. 1, 19 (2005) (concluding the failure to regulate home-consumed marijuana would have a substantial effect on supply and demand "in the national market for that commodity").

Moreover, it is undisputed that Congress relied on *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), as authority for the ACA and that the Supreme Court confirmed therein that the insurance industry is subject to regulation

under the Commerce Clause. Congress thus can properly regulate health insurance, *inter alia*, by prohibiting insurance companies from denying enrollment because of health status in order to ensure universal access to affordable insurance. But, as Washington's experience in the 1990s illustrates, such a system is doomed to fail when people are free to "choose to enter the market only when needing major medical care and dropping coverage after receiving medical treatment." WSB Rep. 6067, *supra*. This inter-relationship – between ensuring access to coverage and keeping such coverage affordable – also supports Congress's authority under the Necessary and Proper clause to adopt the minimum coverage requirements as a corollary to the ACA's access to coverage provisions. *United States v. Comstock*, -- U.S. --, 130 S. Ct. 1949 (2010). The United States Constitution, as interpreted by this Supreme Court in the above cases, permits such a balanced approach to remedy this pressing interstate problem.

C. Uninsured Individuals Cross State Lines To Receive Care, Resulting In Interstate Transfers Of Funds And Economic Burdens By States For The Cost Of Their Care.

Much of the argument has focused on local economic activity and its effect on interstate commerce, but the uninsured and underinsured also cross state lines to obtain care. Many uninsured individuals, who often utilize hospital emergency departments as their primary care provider,[37] travel to nearby states seeking care at safety net hospitals without barriers to access. Residents of southwestern Pennsylvania, for example, rely on access to West Virginia University Hospital ("WVUH"), *see West Virginia Univ. Hosps., Inc. v. Rendell*, 2009 WL 3241849, *14 (M.D. Pa. Oct. 2, 2009), and make over 1500

[37] Peppe, *et al*., Kaiser Family Foundation, *Characteristics of Frequent Emergency Department Users* (Oct. 2007), at 7, 17 (www.kff.org/insurance/upload/7696.pdf).

emergency room visits there each year, *West Virginia Univ. Hosps., Inc. v. Rendell*, 2007 WL 3274409, *2 (M.D. Pa. Nov. 5, 2007).

Similarly, Harborview Medical Center, operated by the University of Washington, is the only Level I trauma center for the four-state region of Washington, Alaska, Montana, and Idaho. Uninsured individuals who suffer catastrophic injuries from accidents and other unpredictable events are transported to Harborview for the care it can uniquely provide. During the five year period from 2006 to 2009, Harborview cared for 11,700 patients from states in the region outside of Washington; of those admitted to the hospital, over 11% were uninsured.[38] The uncompensated care provided by Harborview to patients from these states totaled over $7,500,000 for FY 2010.[39] Many more were on Medicaid, which pays only a portion of hospital care costs.[40] In the last five years, Alaska alone has paid Harborview $15,493,603 for Medicaid patients from that state who received inpatient care.[41] Nor is Harborview's experience unique. The National Foundation for Trauma Care notes, "[A] significant number of trauma patients covered by Medicaid are injured or transported out of state for treatment, but their home State's Medicaid program often refuses or otherwise attempts to avoid payment."[42]

Uninsured individuals have a dramatic impact on interstate commerce regardless of whether they receive treatment within their own or another state. These examples

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[38] Harborview Medical Center/University of Washington Medicine Responses, Public Disclosure Request (June 2010; December 2010) (on file with counsel).
[39] Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request (January 2011) (on file with counsel).
[40] *U.S. Trauma Center Crisis*, *supra*, at 10.
[41] Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request (December 2010) (on file with counsel).
[42] *U.S. Trauma Center Crisis*, *supra*, at 10.

merely demonstrate that it is unrealistic to suppose that the states can address these economic impacts on a state-by-state basis. The reality is quite different: geographic proximity and the location of specialized medical centers, rather than state borders, are key factors in determining the place of care. And when trauma strikes, any person may unexpectedly be transported to another state for care. The magnitude of such activity, involving the consumption of health care services by those who are unable to pay their full cost, is another reason the Governor welcomes the ACA as a federal solution that will both rationalize payment for such care and relieve some of the burden on State resources.

D. The State Needs The ACA To Reduce The Burden Of The Disproportionately High Cost Of Caring For The Uninsured On Everyone Else.

It is generally acknowledged that health care expenditures in America are the highest in the world, without achieving correspondingly good health outcomes.[43] For the uninsured, the problem is particularly severe because many individuals without insurance delay care until their conditions become more difficult and expensive to treat.[44] *See University of Washington Medical Center v. Sebelius*, 634 F.3d 1029, 1030 n.2 (9th Cir. 2011). The uninsured are also more likely to obtain a greater proportion of their medical care from emergency departments, the most expensive level of care, than those with private insurance.[45] Under the current system, the heightened cost of care for the uninsured is borne in substantial part by the State, businesses and insured individuals who

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[43] http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html.

[44] Kaiser Commission for Medicaid & the Uninsured, *Low-Income Adults Under Age 65* (June 2009), at 12 (http://www.kff.org/healthreform/upload/7914.pdf); IOM Report, at 5-8, 57-83.

[45] Peppe, *et al.*, at 7, 17.

must pay higher charges from health care providers seeking to make up for the cost of caring for the uninsured.

The ACA addresses these issues in two ways: first by promoting universal insurance coverage through the minimum coverage provision and other measures that make private insurance more accessible and affordable to all; and second, by promoting improved systems for the delivery of preventive, chronic, and long-term care through investment and realignment of payer incentives. These measures work hand in hand and demonstrate the interconnection between the minimum coverage provisions and the Act's larger goals of reforming and rationalizing the health care and insurance markets. More efficient and effective provision of preventive, chronic, and long-term care will reduce the costs of caring for the uninsured, as well as other patients, by reducing their need for and reliance on more expensive forms of health care services. At the same time, the full impact of these innovations will be realized only if individuals have the insurance coverage to access such care in the first place.

1. The Costs Of Health Care For The Uninsured Are Exacerbated By Their Reduced Access To Primary, Preventive, And Chronic Disease Care.

As one would expect, uninsured individuals nationally and in Washington receive less treatment for their conditions than those with insurance, often with serious consequences.[46] For example, untreated or undertreated hypertension and diabetes are more likely to result in stroke, leading to hospitalization, and stroke victims who did not receive adequate treatment for their underlying conditions are also more likely to suffer

[46] IOM Report, at 74-75; 2009 OIC Report, at 7.

long-term neurologic impairment following a stroke.[47] Many individuals with neurologic impairment are not able to live independently in their own homes, but require long-term care in skilled nursing facilities or adult family homes. Such care, regardless of quality, is extremely expensive; in Washington, it costs an average of approximately $60,000 per year to support a patient in a long term care facility.[48] For those without private insurance, a substantial portion of the cost of such care frequently falls to the State under Medicaid or State-funded safety net programs.[49]

Efforts are underway in Washington to intervene in this trajectory of untreated or undertreated chronic disease leading to acute crises requiring expensive care – and devastation wrought on individual lives. However, key to the success of these efforts is ensuring individuals have the means to access effective care earlier in the course of their diseases.[50] The ACA's minimum coverage requirement, which includes primary, preventive and chronic disease care, *see* 42 U.S.C. § 18022, would provide the means and, consequently, reduce the burden on the State and its citizens of paying for care when the need becomes the most extreme and most expensive.

A recent pilot program for Boeing employees with chronic disease shows what is possible if the means are provided.[51] There, employees and spouses with severe chronic diseases such as diabetes and congestive heart failure, were enrolled in a "medical

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[47] IOM Report, at 76.

[48] Email from Ken Callaghan, Chief, Office of Rates Management, DSHS (January 6, 2011) (on file with counsel).

[49] Davenport, Holin, & Feder, Center for American Progress, *The "Dual Eligible" Opportunity: Improving Care & Reducing Costs for Individuals Eligible for Medicare & Medicaid* (Dec. 2010), at 3 (www.americanprogress.org/issues/2010/12/pdf/dual-eligibles.pdf).

[50] McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 Millbank Quarterly 443, 476 (June 2009).

[51] http://www.wsma.org/files/Downloads/NewsEvents/ReportsPreceptor/may-june_reports10.pdf 1, 3 (May/June 2010).

home." The medical homes, based in three primary care clinics, provided intensive outpatient care, extensive evaluation, screening and diagnostic testing, and a care plan administered by a clinic team, including a nurse care manager. In the first 12 months of the study, health care costs for this population fell by 20%, due mostly to reduced emergency room visits and hospitalizations.[52] Further, workdays missed by patients assigned to this program declined by 56.5%, with obvious implications for their productivity as well as that of their employer.[53]

King County, the most populous county in the State, is attempting to address the needs of a similar population in terms of disease burden (those with diabetes, asthma and obesity) in an area where 30% of the population is low income. This population has limited access to primary care, and those with diabetes and asthma are hospitalized at twice the rate of those with the same conditions in the rest of the County.[54] Through the Steps to Health Program, the County supported clinics in taking a comprehensive approach to these patients, including use of case managers and home visits to educate patients in self-management of their conditions. Results of the program were promising: emergency room visits declined by 40% in the population that was provided case management services, and hospitalizations for asthma declined four times more in the target area than in King County as a whole.[55] The funding provided by the CDC for this program has ended, but its approach to care for at-risk individuals could be carried forward and made available to other low-income individuals if they had insurance.

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[52] http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable.
[53] *Id.* at 4.
[54] *King County Steps to Health*, http://www.kingcounty.gov/healthservices/health/chronic/steps.aspx.
[55] Steps to Health King County: Summary Evaluation Report March 2009, at 8, 18 (http://www.kingcounty.gov/healthservices/health/chronic/steps.aspx).

The Governor has a strong interest in seeing that the consumption of health care services by Washington residents with severe chronic disease occurs in a way that better meets their needs and avoids, where possible, costly hospitalizations and long-term care. Too often, under the current system, the State pays for care for uninsured individuals who do not get the right care in time to avoid the hospital or nursing home. Even those with Medicare coverage often must turn to programs funded in whole or part by the State if they have long-term care needs, because Medicare does not cover such care.[56] In FY 2009 in Washington, over 126,000 individuals were eligible for Medicare, but still required state funding for coverage of long-term care needs.[57] The State spent $2 billion in FY 2009 on care for such individuals who did not have private long-term care insurance.[58] Thus, the State has a strong economic interest in a requirement that residents carry insurance that covers preventive care and chronic disease management.

Twenty percent (20%) of children are also afflicted with chronic illness, including asthma, persistent ear infections, allergies, and diabetes.[59] National studies show that access to preventive and primary care reduces hospital admissions for such conditions, which can be more effectively treated in the outpatient setting if caught early and addressed by a continuous source of care.[60] The cost in Washington of the average

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[56] *See* www.medicare.gov/longtermcare/static/home.asp

[57] Washington Department of Social & Health Services, *Coordinating Care for Washington State Dual Eligibles* (Sept. 2011). These individuals comprise "some of the sickest and poorest patients in our nation's health care system." Davenport, *supra*, at 1. They are often referred to as "dual eligibles" because they qualify for Medicare by reason of age or disability and for Medicaid on the basis of low income. *Id.*

[58] Washington Department of Social & Health Services, *Coordinating Care for Washington State Dual Eligibles* (Sept. 2011).

[59] Institute of Medicine, *America's Children: Health Insurance and Access to Care* (1998), at 120.

[60] Szilagyi, *et al., The Scientific Evidence for Health Insurance,* 9 Acad. Pediatr. 4-6 (2009); Christakis, *et al., Is Greater Continuity of Care Associated with Less Emergency Department Utilization?*, 103

pediatric hospital admission for just one of those conditions, asthma, is over $3,000, while the average cost of a primary or preventive care visit ranges from $83 to $92.[61]

Washington's Apple Health for Kids program, created in 2008, streamlines enrollment for children in state-administered insurance plans.[62] As a result, thousands of previously uninsured children now have access to primary and preventive care. Washington's efforts to maintain coverage for children are supported, in significant part, by a federal grant awarded to states annually based on performance.[63] However, the success of a program like Apple Health should not depend on a yearly grant process. Rather, the Governor endorses the approach embodied in the ACA, which would provide reliable coverage to the most children and ensure ongoing access to care in the most appropriate setting, from the perspective of both cost and the health of the children.

2. The Minimum Coverage Provision Is Necessary to Alleviate The Unfair Burdens Placed On Employers, Insured Individuals, Health Care Providers, And The State By The Costs Of The Uninsured.

Given the inevitability of the need for health care and its high cost, the notion that individuals can choose to opt out of the health care market or simply "pay as they go" is a fallacy. Instead, by deciding not to purchase insurance, the uninsured shift the costs of their health care to other participants in the health care market, including the State, health care providers, and businesses and individuals who do purchase insurance. In Washington, uncompensated care provided by hospitals and other providers totaled

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Pediatrics 738-42 (1999); Baker Institute Policy Report, *The Economic Impact of Uninsured Children on America* (2009), at 4, 5.

[61] http://www.childrensalliance.org/resouce-center/fact-sheet-federal-bonus-apple-health-kids; Jonathan Seib, Executive Policy Advisor, Governor of Washington's Executive Policy Office (email comm. March 7, 2011) (on file with counsel).

[62] http://hrsa.dshs.wa.gov/applehealth/.

[63] http://www.childrensalliance.org/resource-center/fact-sheet-federal-bonus-apple-health-kids.

approximately $1 billion in 2011.[64] These costs impose substantial burdens on families and employers, because of cost-shifting to insured patients, and on State government, which provides significant subsidies to hospitals and clinics with large volumes of uninsured patients. *See University of Washington Medical Center v. Sebelius*, 634 F.3d at 1032 & n.4 (describing the State's subsidization of hospital care for the uninsured).

State subsidies to hospitals with large numbers of such patients are provided through the "disproportionate share" program ("DSH"). *See University of Washington Medical Center v. Sebelius*, 634 F.3d at 1031-32 (describing operation of DSH payments). The cost of these payments to the State is substantial: total state funding for DSH payments to Washington hospitals in FY 2011 was approximately $150 million.[65] However, despite DSH payments, the volume of uncompensated care is becoming increasingly unsustainable for providers, particularly public safety net hospitals. For example, Harborview went from providing $27,041,000 in charity care in 2000 to $186,733,000 in FY 2010, of which only a portion is offset by DSH payments.[66]

Of additional concern is the "spillover effect" that high levels of uninsurance can have on the supply and quality of health care available to all residents, whether insured or not. Research has shown that even insured individuals in communities with high levels of the uninsured are less likely to have a regular doctor and experience more difficulty accessing specialty and emergency room care than individuals in communities where

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[64] 2011 OIC Report, at 1, 10.

[65] http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=49.

[66] Washington State Department of Health, *Washington State 2000 Charity Care in Washington Hospitals* (July 2002), at 10 (http://www.doh.wa.gov/EHSPHL/hospdata/CharityCare/Reports/2000CharityCarein WashingtonState.doc); Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request (January 2011).

more people are insured.[67] Moreover, reports from both primary care providers and specialists indicate that the higher the uninsurance rate in their community, the less able they are to deliver high quality care to all residents.[68] These effects have been attributed, in part, to the problem of capital investment and providers being more likely to move toward more affluent communities, with a resulting negative effect on capacity in communities with high uninsurance rates to provide care to all patients.[69]

Families and businesses who purchase insurance also shoulder the burden of the present system. As mentioned above, each insured family in Washington pays an estimated $1,017 per year more in medical bills to help defray the cost of caring for the uninsured.[70] The increases in premiums and health care costs that have occurred, in significant part to pay for the uninsured, are staggering. Between 1991 and 2004, health care costs in the State grew at an average rate of 7.3% per year.[71] In 2009, 1.2 million insured Washingtonians spent more than 10% of their pre-tax income on health care.[72] The mounting cost of insurance has had an inevitable and debilitating effect on the number of employers offering insurance and the number of individuals buying it. While 76% of employers in Washington insured their full-time employees in 2003, by 2011, only 53.5% of firms did.[73] According to the Washington Insurance Commissioner, the determining factor in whether a person has insurance is their income level, *i.e.*, whether

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[67] Pauly & Pagan, *Spillovers and Vulnerability: The Case of Community Uninsurance,* 26 Health Affairs 1304, 1309-10 (2007).
[68] *Id.*
[69] IOM Report, at 10.
[70] 2011 OIC Report, at 1.
[71] www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=5&rgn=49&ind =595&sub=143.
[72] 2009 OIC Report, at 9.
[73] Washington State Employment Security Department, *2003 Employee Benefits Survey* (March 2004); *2010 Washington State Employee Benefits Survey*, at 7.

they can afford the high cost of insurance.[74] Among those in the wage-earning sector in Washington, the breakpoint is at approximately $35,000 in annual income: with wages above that level, most employees have insurance through their employers, whereas below that level, most do not.[75]

Thus, companies in Washington that voluntarily provided health benefits to their employees in the past have been forced out of the market by premium increases driven in part by the high spillover costs of caring for the uninsured. Even when employers offer insurance, it has become increasingly unaffordable for their employees.

In sum, the cost of caring for the uninsured creates a downward spiral in which the unaffordability of insurance leads to increasing numbers of the middle class joining the ranks of the uninsured. This has created a situation in Washington in which most affluent persons have health insurance and most children and elderly persons are covered through a combination of public programs and private insurance, but a large portion of the wage-earning sector of the population is left out in the cold.[76] The minimum coverage provision is necessary to rectify this situation and achieve a functioning, national insurance market that is not distorted by either the exclusionary practices of the insurance companies, on the one hand, or the decisions of individuals to forego health care coverage unless and until they need health care treatment, on the other. Without the minimum coverage and related insurance reforms under the ACA, Washington State, its health care providers, employers, and insured residents would be forced to bear ever

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[74] 2009 OIC Report, at 5.
[75] Email from Jim Keogh, Economic Policy Analyst, Washington Office of Insurance Commissioner (December 23, 2011) (citing Washington Medical Expenditure Panel Survey data) (on file with counsel).
[76] 2011 OIC Report, at 6, 8.

greater costs of treatment for uninsured people who suffer catastrophic medical events or fail to get preventive care that could avoid the development of significant medical conditions.

VI. CONCLUSION

For the reasons stated above, the Governor believes that the ACA's minimum coverage provision is a legitimate regulation of economic activity and a necessary and proper exercise of Congressional authority to address the economic impacts of the uninsured on the interstate health care and health insurance markets.

Respectfully submitted,

KRISTIN HOUSER*
ADAM J. BERGER
REBECCA J. ROE
WILLIAM RUTZICK
SCHROETER, GOLDMARK & BENDER
810 Third Avenue, Suite 500
Seattle, Washington 98104
Telephone: (206) 622-8000

Counsel for Amicus Curiae
**Counsel of Record*