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Kinder v. Geithner - American Association of People With Disabilities Amicus Brief

American Association of People with Disabilities

Case No. 11-1973

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETER KINDER, et al.,
Plaintiffs-Appellants,
-vs.-
TIMOTHY GEITHER, et al.,
Defendants-Appellees.

On Appeal from the United States District Court for the Eastern District of Missouri- Cape Girardeau in No. 1:10-CV-00101-RWS
(Hon. Rodney W. Sippel, U.S. District Judge)

AMICUS CURIAE BRIEF OF THE AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES, THE ARC OF THE UNITED STATES, FAMILIES USA, FRIENDS OF CANCER RESEARCH, MARCH OF DIMES FOUNDATION, MENTAL HEALTH AMERICA, NATIONAL BREAST CANCER COALITION, NATIONAL ORGANIZATION FOR RARE DISORDERS, AND THE NATIONAL SENIOR CITIZENS LAW CENTER IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, counsel certifies that (a) no signatory to this brief has a parent corporation and that no publicly held corporation owns 10 percent or more of its stock; and (b) *amici* are leading organizations dedicated to helping those individuals facing insurance denials and rejections due to pre-existing conditions, including organizations dedicated to reducing the incidence of and the impact of major diseases, disorders, and disabilities, and engaged in advocacy on behalf of individuals affected with such conditions.

August 16, 2011

Respectfully Submitted,

/s/Rochelle Bobroff
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INTERESTS OF AMICUS CURIAE[1]

Amici are leading organizations dedicated to helping those individuals facing insurance denials and rejections due to pre-existing conditions, including organizations dedicated to reducing the incidence of and the impact of major diseases, disorders, and disabilities, and engaged in advocacy on behalf of individuals affected with such conditions. *Amici* have amassed invaluable knowledge of the impact of these conditions and of the history of remedies and policies aimed at lessening these impacts. *Amici* represent the interests of individuals who are at risk of serious financial and medical consequences, if they cannot obtain insurance to cover the costs of their medical care. Such individuals are thus tangibly and profoundly harmed by health insurers' practice of denying coverage to persons with pre-existing medical conditions and other abuses that are prohibited by the insurance reforms in the ACA, to which the minimum coverage provision is integral and essential.[2] Moreover, the barriers to affordable coverage

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[1] Pursuant to Federal Rule of Appellate Procedure 29(c)(5), counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, its members or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this *amicus* brief, pursuant to Federal Rule of Appellate Procedure 29(a).

[2] "Minimum coverage provision" is the phrase employed in this brief for the statutory requirement to carry minimum levels of insurance or pay a penalty – what is sometimes referred to as the "individual mandate."

eliminated by the ACA increase financial costs and compound medical threats for the entire population, since lack of access to affordable health insurance impedes timely diagnosis and treatment, postponing remedial action until remedies are both more expensive and less effective. Hence, *amici* have both a strong interest in preserving the insurance reforms in the ACA and the capacity to offer information that illuminates the soundness of Congress' conclusion that the minimum coverage provision is critical to the success of these vital reforms. All parties consented to the filing of this brief.

SUMMARY OF ARGUMENT

Because the district court correctly determined that it lacks subject matter jurisdiction over this case, there is no need for this Court to reach the merits of appellants' claims. Nevertheless, should this Court decide to reach the merits, empirical evidence and analysis demonstrate that Congress correctly concluded that a minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold."[3] Patient

[3] "Guaranteed issue" refers to requirements that insurers accept specified applicants for coverage, e.g., small businesses applying for coverage. "Exclusion of coverage of pre-existing conditions" refers to the practice of denying coverage to persons who have or have had illnesses or conditions that could require treatment during the policy period. Kaiser Family Foundation, *How Private Health Coverage*

Protection and Affordable Care Act ("ACA"), Pub L. No. 111-148, 124 Stat. 119 § 1501(a)(2)(G) (2010). In particular, the evidence presented here shows that every single state that required insurers to cover pre-existing conditions without also enacting a minimum coverage provision had disastrous results.

Individuals who do not carry insurance are nonetheless participants in the health care market and, collectively, shift billions of dollars of costs onto third parties. Cong. Budget Office, Key Issues in Analyzing Major Health Proposals 114 (2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf. The minimum coverage provision addresses this cost-shifting and forms an essential part of the ACA's broader reforms. In particular, one of the most problematic of the insurance industry practices targeted by the ACA – the exclusion from coverage of persons with pre-existing medical conditions – depends upon a minimum coverage provision.

ARGUMENT

I. THE EXPERIENCE OF THE STATES DEMONSTRATES THAT ENSURING COVERAGE FOR PERSONS WITH PRE-EXISTING MEDICAL CONDITIONS HAS WORKED ONLY WITH A COMPLEMENTARY REQUIREMENT THAT PERSONS WHO CAN AFFORD IT CARRY HEALTH INSURANCE

Works: A Primer, 2008 Update (April 2008), *available at* http://www.kff.org/insurance/upload/7766.pdf.

Congress' judgment that the minimum coverage provision is integral to barring exclusions for pre-existing conditions and other insurance reforms was based on considerable evidence demonstrating that, without such a requirement, "many individuals will not choose to obtain coverage … [and] adverse selection will occur . . . ." Linda J. Blumberg & John Holahan, *Do Individual Mandates Matter?*, Urban Institute, Jan. 2008, *available at* http://www.urban.org/uploadedpdf/411603_individual_mandates.pdf. "Adverse selection" occurs when persons with a higher than average health risk disproportionately enroll in a given insurance plan. Currently healthy consumers will tend to delay the purchase of health insurance until they become ill or injured – forcing the insurer to pay them substantially more in benefits than they have previously paid in premiums, and increasing premiums for those who are insured. *See Fed. Ins. Co. v. Raytheon Co.*, 426 F.3d 491, 499 (1st Cir. 2005).

In hearings before Congress, testimony on behalf of the National Association of Insurance Commissioners noted that due to the "severe adverse selection" resulting from the "elimination of preexisting condition exclusions for individuals, State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussion on Expanding Health Care Coverage: Hearing Before the Senate*

Finance Committee, 111th Cong. 3 (2009) (statement of Sandy Praeger, Chair of the Health Insurance and Managed Care Committee, National Association of Insurance Commissioners). Indeed, "[w]ithout the individual mandate, fundamental insurance-market reform is impossible[.]" Jonathan Gruber, *Getting the Facts Straight on Health Care Reform*, 361 New Eng. J. of Med. 2497, 2498 (2009), at http://healthcarereform.nejm.org/?p=2473.

But Congress' judgment was not merely supported by research and analysis. The need to couple insurance reform with a minimum coverage provision had been demonstrated by the actual experience of states which have tried to do otherwise and – without exception – failed.

A. State Bans On Excluding From Coverage People With Pre-Existing Conditions That Were Not Accompanied By A Minimum Coverage Provision Have Been Unsuccessful

Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington enacted legislation that required insurers to guarantee issue to all consumers in the individual market[4], but did not have a minimum coverage provision. *See* Ky. Rev. Stat. Ann. § 304.17A-060(2)(A) (West)(Kentucky, repealed); Me. Rev. Stat. Ann. Tit. 24-A. § 2736-C(3) (Maine); N.H. Rev. Stat. Ann. § 420-G:6 (1994)(New Hampshire); N.J. Stat. Ann. § 17B:27A-22

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[4] "Individual market" refers to the market for health insurance policies for individuals not covered by employer-sponsored or other group health plans.

(West)(New Jersey); NY CLS Ins § 3231, 3232 (New York); Vt. Stat. Ann. tit. 8, § 4080B(d)(1)(Vermont); Wash. Rev. Code § 48.43.012(1)(Washington). All of these laws have had detrimental effects on the insurance markets in those states. All seven states suffered from sky-rocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers.

"The departure of nearly all insurers from Kentucky's individual market is probably the most widely known aspect of its reforms." Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Heath Politics, Pol'y & L. 133, 152 (2000) ("Riding the Bull"). By late 1996, only two providers were still selling new policies in Kentucky's individual market, and the most commonly cited reason given by the departing companies to explain their departure was the pre-existing conditions provision. *Id.* at 152–53. Kentucky's reforms were eventually repealed in 1998. *See* 1998 Kentucky Laws Ch. 496 (H.B. 315).

Maine experienced a similar loss of insurance providers from its individual market after its pre-existing conditions provision was enacted in 1993. A 2001 report found that 13 of 18 major carriers ceased issuing new policies to individuals during the eight years since the provision became law. Maine Bureau of Insurance, *White Paper: Maine's Individual Health Insurance Market*, January 22, 2001, at 8 ("White Paper"). The report had equally grim news about costs. Many insurance

providers doubled their premiums in just three years or less, and all but one of the state's HMOs experienced "at least one rate increase of 25% or more in 1998 or 1999." *Id.* at 6, 7 & 10.

The same Maine report cited New Hampshire as a cautionary tale of a state whose individual indemnity market completely collapsed. According to the report,

> New Hampshire was nearly left with no carriers in the market when Blue Cross Blue Shield of New Hampshire announced it was withdrawing from the individual market. The New Hampshire Insurance Department took emergency measures to preserve the market. Under the system adopted through emergency rulemaking, and later by statute, all group health insurance and excess loss carriers in New Hampshire are assessed an amount (36 cents monthly in 2000) per covered person. Funds are distributed to individual carriers according to a formula designed to compensate those with large losses.

Id. at 5. In 2003, New Hampshire amended its law to permit pre-existing conditions to be excluded for 9 months. Act of May 19, 1997, ch. 188, sec. 11, § 420-G:7, I(a) (2003). After New Jersey's pre-existing conditions provision took effect in 1993, individual insurance market premiums skyrocketed. Between 1996 and 2001, the cost of the most generous individual insurance plans rose by more than 350 percent. Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23.4 Health Affairs 167, 169–70 (2004). Even HMO plans, which tend to resist premium increases, nearly doubled in price during this same timeframe. *Id.*

New York enacted pre-existing condition provisions for the individual market in 1993. Consequently, the portion of non-elderly New Yorkers without insurance worsened from 16.5 percent in 1992 to 20 percent in 1997; while during the same period of time the national average of Americans without coverage worsened from 17.8 percent to 18.4 percent. Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & L., 71, 76-77 (2000). A study of the New York individual market concludes that "[f]ollowing reform, the overall percentage of the population with insurance has worsened, and enrollment in the individual market has steadily diminished. Prices have increased substantially more than in other portions of the market, due to adverse selection." *Id.* at 97.

Like New York, Vermont saw substantial increases in premiums after its similar insurance reform measures took effect in 1993. Mark A. Hall, *An Evaluation of Vermont's Reform Law*, 25 J. Health Politics, Pol'y & L. 101, 115 (2000).

Severe consequences resulted from Washington's law. Within just a few years, non-managed care options disappeared entirely from the individual market. Riding the Bull at 140; White Paper at 5. Among HMOs in the individual market, "[t]he trend since 1994 has been toward higher deductible and/or more managed products as insurers have progressively closed lower deductible, less tightly managed products." Riding the Bull at 140. The state's only insurer in the

individual policy market stopped selling new individual policies. *Id.* By 2000, some Washington counties had no private individual coverage available at all. White Paper at 5. In 1999, the Washington state legislature modified its law to permit insurers to deny coverage to certain high-risk consumers.[5]

Recent experience with the early implementation of ACA indicates similar results in the national market when a pre-existing conditions provision is not accompanied by a minimum coverage provision. In September 2010, a nationwide pre-existing conditions provision for children went into effect under the ACA. Pub L. No. 111-148 § 10103(e). Immediately thereafter, several large insurance companies stopped offering new child-only insurance policies. A.C. Aizenman, *Major Health Insurers to Stop Offering New Child-Only Policies*, Washington Post, (Sept. 20, 2010). A health insurance industry spokesperson explained that "[w]ith no … mandate currently in place, … the result over the next several years [until 2014, when the minimum coverage provisions takes effect] could be that the pool of children insured by child-only plans would rapidly skew toward those with expensive medical bills, either bankrupting the plans or forcing insurers to make up their losses by substantially increasing premiums for all customers." *Id*.

[5] Some other aspects of Washington state's health reform have been successful. Carol M. Ostrom, *Washington 'a Step Ahead' of Health Law*, Seattle Times, Apr. 1, 2010, *available at* http://seattletimes.nwsource.com/html/localnews/2011504803_statehealthreform02m.html.

Based on this experience of the states as well as the early implementation of ACA, it is totally foreseeable that the pre-existing conditions exclusion will not succeed without the minimum coverage provision. Thus, it is predicted that premiums in 2019 are likely to rise 27% without the minimum coverage provision. Jonathan Gruber, "Health Care Reform is a 'Three-Legged Stool,'" (2010), *available at* http://www.americanprogress.org/issues/2010/08/pdf/repealing_reform.pdf. The Congressional Budget Office also estimates that, without the minimum coverage provision, the number of newly insured individuals will be cut in half. Congressional Budget Office, "Effects of Eliminating the Individual Mandate to Obtain Health Insurance" (2010).

An unbroken pattern shows that pre-existing conditions provisions, absent a minimum coverage provision, are a failed experiment. At best, they result in premium increases. At worst, they cause the total collapse of a state's individual insurance market.

B. Massachusetts Successfully Banned Excluding From Insurance Plans Patients With Pre-existing Conditions By Requiring Minimum Coverage

Where seven states failed, the state of Massachusetts succeeded by implementing reforms similar to the ACA. *See* Jonathan Gruber, Massachusetts Institute of Technology, The Senate Bill Lowers Non-Group Premiums: Updated for New CBO Estimates 1 (2009) ("Senate Bill Lowers"). Indeed, Congress cited

Massachusetts‘ health reform as a model for the ACA. Pub L. No. 111-148 § 10106(a).

In mid-2006, Massachusetts Governor Mitt Romney signed a health reform bill which included a minimum coverage provision. Mass. Gen. Laws ch. 111M, §§ 1-5. Massachusetts law already had a pre-existing conditions provision. Mass. Gen. Laws ch. 176M, § 3(a). The results were both striking and immediate. Although nationwide individual premiums increased an average of 14 percent over the next few years, "the average individual premium in [Massachusetts] fell from $8537 at the end of 2006 to $5143 in mid-2009, a *40% reduction while the rest of the nation was seeing a 14% increase*." Senate Bill Lowers at 1 (emphasis in original).

The lesson of Massachusetts and the other seven states is clear. A pre-existing conditions provision must have an accompanying minimum coverage provision to be successful. Because a minimum coverage provision is essential to enacting the ACA's pre-existing conditions provision, it falls squarely within Congress' authority under the Commerce and Necessary and Proper Clauses. Congress does not simply have the power to regulate interstate commerce, "'it possesses every power needed to make that regulation effective.'" *Gonzales v. Raich*, 545 U.S. 1, 36, 125 S.Ct. 2195, 2217 (2005) (Scalia, J., concurring in the

judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19, 62 S Ct. 523, 526 (1942)).

The court in *Florida v. Department of Health and Human Services.*, No. 3:10-cv-91, 2011 U.S. Dist. LEXIS 8822 (N.D. Fl. Jan. 31, 2011) created an additional limit on Congress' Necessary and Proper power—suggesting that Congress may not invoke this power to "avoid the negative consequences that will potentially flow from its own statutory enactments." *Id.* at 115. It is, of course, incorrect to suggest that the ACA creates a negative consequence—rather, the minimum coverage provision is an essential and integral component of the scheme that Congress designed to achieve its legitimate objective of ending preexisting conditions exclusions while preserving an affordable private individual insurance market. Automobiles have engines and gas pedals so they can move – their primary purpose – but they also have steering wheels and brakes so their motion can be controlled; the ACA is no different. As demonstrated by academic studies and the extensive experience of the states, combining mandatory coverage of pre-existing conditions with a minimum coverage provision achieves Congress' objective without negative consequence.

Ultimately, however, it is irrelevant whether the minimum coverage provision is merely directed at "avoiding negative consequences" flowing from

other provisions of law because *Florida*'s entirely novel limit on the Necessary and Proper power cannot be squared with precedent.

In *United States v. Comstock*, 130 S. Ct. 1949 (2010), the Court held that, when the federal government endangers the safety of a community by incarcerating "sexually dangerous" inmates nearby, it may detain those inmates beyond the length of their sentence in order to remove the danger created by such incarceration. *Id.* at 1961; *see Id.* at 1968 (Kennedy, J., concurring in the judgment) (explaining that Congress may exercise its necessary and proper power to ensure that another provision of law does "not put in motion a particular force . . . that endangers others"). Just as Congress may legislate to "avoid the negative consequences" of the criminal law, it may also legislate to ensure that the preexisting conditions provision does not spark an adverse selection spiral that threatens the national health insurance market.

II. INDIVIDUALS WHO CHOOSE TO FOREGO INSURANCE SHIFT BILLIONS OF DOLLARS OF COSTS TO OTHER PARTICIPANTS IN THE HEALTH INSURANCE AND SERVICES MARKET

Uninsured individuals fall into three categories: some individuals cannot afford insurance coverage, some are denied coverage because of pre-existing conditions, and some choose to forego purchasing insurance in the hope that they will never require expensive medical treatment or that if they do, it will be

available in any event. Uninsured individuals seeking care for pre-existing conditions or who have unexpected health care costs due to illness or injury can lead to increased costs for other, insured Americans. This is because "[t]hose who are uninsured are less likely to get the care that they need when they need it and are more likely to delay seeking care—often until a condition becomes so serious that treatment can no longer be put off." Christine Sebastian et al., *Health Reform: Help for Americans with Pre-Existing Conditions*, Families USA, May 2010, at 9, *available at* http://www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions.pdf ("Help for Americans"); *see also* Committee on the Consequences of Uninsurance, Institute of Medicine, Health Insurance is a Family Matter 106 (2002) ("Uninsured children often receive care late in the development of a health problem or do not receive any care. As a result, they are at higher risk for hospitalization for conditions amenable to timely outpatient care and for missed diagnoses of serious and even life-threatening conditions.").

Under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, however, a patient who allows his condition to deteriorate until it requires expensive treatment to stabilize must still receive treatment from most emergencies rooms even if he is unable to pay. Cong. Budget Office, Key Issues in Analyzing Major Health Proposals 13 (2008). These high costs of stabilizing a dangerous condition are then distributed to other consumers.

According to a recent study, this "hidden tax" on health insurance accounts for roughly 8 percent of the average health insurance premium. Ben Furnas & Peter Harbage, *The Cost-shift from the Uninsured*, Center for Am. Progress, March 24, 2009, *available at* http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf. This cost-shift added, on average, $1,100 to each family premium in 2009 and about $410 to an individual premium. In a high-cost state such as Florida, the cost-shift is even greater, increasing annual average family premiums by $1,400 and individual premiums by $510 per year. *Id*.

For those who can afford health insurance coverage, and choose not to purchase care, the decision to remain uninsured is clearly an economic calculation with adverse consequences for other market participants. Those who opt to self-insure can virtually never guarantee that, when faced with a life-threatening illness or traumatic injury, that they will bear all their health care costs or forego necessary treatment. According to a recent study, the cost of active treatment for prostate cancer had an average 2-year cost of $59,286. E.D.Crawford *et al.*, *A Retrospective Analysis Illustrating the Substantial Clinical & Economic Burden of Prostate Cancer*, 13 Prostate Cancer & Prostatic Diseases 162 (2010). For colorectal cancer patients, the cost of treatment can exceed hundreds of thousands of dollars. The cost of drugs alone can range from $150,000 to $200,000 for a course of treatment. Neal J. Meropol & Kevin A. Schulman, Kevin, A., *Cost of*

Cancer Care: Issues and Implications, 25 J. Clinical Oncology 180 (2007), *available at* http://dceg.cancer.gov/files/genomicscourse/meropol-011007.pdf. In comparison, U.S. Census Bureau data shows, median household income for 2007 was $50,740, and median household net worth in 2007 was $120,300. U.S. Census Bureau, 2010 Statistical Abstract: Income, Expenditures, Poverty & Wealth (2009), *available at* http://www.census.gov/compendia/statab/cats/income_ expenditures_poverty_wealth.html.

By enhancing access to insurance, the pre-existing conditions provision increases the likelihood that patients will seek treatment early, and thus will not pass on elevated costs to other consumers.

III. THE MINIMUM COVERAGE PROVISION, TOGETHER WITH THE PROHIBITION ON EXCLUSIONS FOR PRE-EXISTING CONDITIONS, CAN BE EXPECTED TO REDUCE HEALTH CARE COSTS, PREVENT MEDICAL BANKRUPTCIES, ENCOURAGE FLUIDITY IN THE JOB MARKET, AND ELIMINATE THE ECONOMIC COSTS FROM UNNECESSARY DEATHS

The harm from the exclusions for pre-existing conditions cuts across the entire U.S. population. An estimated 57.2 million Americans under the age of 65 suffer from a pre-existing condition. Help for Americans at 2. A congressional investigation conducted after passage of the ACA found that the four largest U.S. for-profit health insurers denied policies to one out of every seven applicants based on their prior medical history. H. Comm. on Energy and Commerce Memorandum,

111th Cong., *Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market* 1 (Oct. 12, 2010). Congress also found that pregnant women, fathers-to-be and those attempting to adopt children are generally unable to buy policies on the individual insurance market. *Id*.

A. The Pre-existing Conditions Provision Will Reduce Health Care Costs For Millions of Americans

Many of the 57.2 million Americans with pre-existing conditions currently can be denied coverage outright, forcing them to pay even catastrophic medical costs out-of-pocket. *See* Karen Pollitz *et al*., *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?*, Kaiser Fam. Found., June 2001, at 31, *available at* http://www.kff.org/insurance/20010620a-index.cfm ("How Accessible") (finding that insurers in the individual market consider certain conditions to be "uninsurable"). Yet even very minor conditions can lead to denials of coverage—one study found that individual insurers will deny coverage to a young, otherwise-healthy woman 8 percent of the time simply because she suffers from hay fever. *Id.* at 7. Likewise, temporary conditions such as pregnancy can be grounds for complete denial of insurance, *id.* at 19 n.27, potentially imposing enormous unanticipated costs on uninsured women, *see* Committee on Understanding Premature Birth & Assuring Healthy Outcomes, Institute of Medicine, Preterm Birth: Causes, Consequences, and Prevention 398 (2007)

("Preterm Birth") (estimating the total costs of medical treatment for preterm births alone to be $16.9 billion in 2005).

The weight of pre-existing condition exclusions falls particularly hard on women. Women are more likely than men to suffer from chronic conditions. *See* Alina Salganicoff et al., *Women and Health Care: A National Profile*, Kaiser Fam. Found., Jul. 2005, at 8, *available at* http://www.kff.org/ womenshealth/7336.cfm. Insurance companies have denied coverage to women based solely on their history of having had a Cesarean section or required them to show proof of sterilization. Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. Times, June 1, 2008, at A26, *available at* http://www.nytimes.com/2008/06/01/health/01insure.html. Survivors of domestic violence may also face pre-existing condition coverage denials, National Women's Law Center, Nowhere to Turn: How the Individual Health Insurance Market Fails Women 8 (2008), *available at* http://nwlc.org/reformmatters/NWLCReport-NowhereToTurn-WEB.pdf.

About 13.5 million children have special health needs, Ha T. Tu & Peter J. Cunningham, *Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs*, Center for Studying Health Sys. Change, Sept. 2005, at 1, *available at* http://www.hschange.com/CONTENT/778/778.PDF. But pre-existing conditions are most common among older Americans. Nearly half of all adults

between the ages of 55 and 64 suffer from a pre-existing condition, and thus could be denied insurance coverage absent the ACA's pre-existing conditions provision. Help for Americans at 3.

Other individuals with pre-existing conditions will be issued insurance only if they agree to pay increased premiums, accept a higher co-payment or deductible, exclude their pre-existing condition from coverage, accept an annual or lifetime cap on coverage, or all four. How Accessible at i–iii & 24. Insurers typically substantially limit the benefits available to children with long-term health conditions. Treatment such as rehabilitation services, for example, is "usually limited to 3 months after an acute event that usually requires hospitalization." Preterm Birth at 459.

For Americans denied meaningful access to health insurance, every illness is a potential brush with economic ruin. The pre-existing conditions provision will remove this risk, also removing a substantial burden to interstate commerce in the process.

B. The Pre-existing Conditions Provision Will Reduce Medical Bankruptcies

At its core, health insurance exists to "distribute[] risk" away from an individual unfortunate enough to be struck with an expensive illness or injury and spread these costs among a large pool of individuals. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 239, 99 S. Ct. 1067, 1087 (1979). Without access

to insurance, persons with pre-existing conditions are constantly at risk of being struck by an unaffordable hospital bill, forcing them to declare bankruptcy. Likewise, Americans who can afford insurance but choose not to purchase it impose significant burdens on interstate commerce when they subsequently declare bankruptcy to escape from medical bills they cannot afford to pay.

Congress found that "[h]alf of all personal bankruptcies are caused in part by medical expenses," Pub L. No. 111-148 § 1501(a)(2)(E). One study estimates that "62.1% of all bankruptcies have a medical cause," and the share of bankruptcies attributable to such causes increased by 50 percent between 2001 and 2007. David U. Himmelstein et al., Medical Bankruptcy in the United States, 2007: Results of a National Study, 122 Am. J. of Med. 741, 742 (2007). The pre-existing conditions provision will increase access to insurance, reducing the number of patients hit by catastrophic bills and decreasing the substantial burden medical bankruptcies impose on interstate commerce.

C. The Pre-existing Conditions Provision Will Reduce "Job Lock"

Because employer-provided health plan participants typically enjoy legal protections against exclusion, *see* 29 U.S.C. §§ 1181, 1182, the only way for many people with pre-existing conditions to secure coverage is to receive insurance through an employer. *See* How Accessible at 19 n.27 (finding that insurers in the individual market consider certain conditions to be "uninsurable"). Thus, absent

the pre-existing conditions provision, thousands of American workers will forego a job opportunity because of fear that they will be uninsured if they leave their current job. This "job lock" phenomenon "accounts for a 25–30 percent reduction in [job] mobility." Brigitte C. Madrian, *Health Insurance and Job Mobility: Is There Evidence of Job-Lock?*, 109 Q. J. of Econ. 27, 43 (1994); *see also* Kevin T. Stroupe et al., *Chronic Illness and Health Insurance Related-Job Lock*, 20 J. Pol'y Analysis & Mgmt. 525, 525 (2001) (finding that workers with chronic illnesses or a family member with chronic illness are 40 percent less likely to voluntarily leave a job which provides health benefits than a similarly-situated healthy worker with a healthy family). Moreover, Congress was well aware of job lock when it debated the ACA. *See Terminations of Individual Health Policies by Insurance Companies: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. On Oversight and Investigations*, 111th Cong. (2009) (statement of Jennifer Wittney Horton) ("I have had to take jobs that I do not want, and put my 22 career goals on hold to ensure that I can find health insurance."); President Barack Obama, Address to a Joint Session of Congress (Sep. 9, 2009) ("More and more Americans worry that if you . . . change your job, you'll lose your health insurance too.").

Excluding individuals with pre-existing conditions from coverage stifles entrepreneurship; it leads workers to choose large employers over promising young

companies; it forces workers to limit their career path to jobs which offer health benefits; and it discourages workers from going where their talents lead them. By eliminating such exclusions in the individual market, the ACA will significantly reduce—if not eliminate altogether—these substantial burdens to interstate commerce.

D. The Pre-existing Conditions Provision Will Reduce Preventable Deaths

Finally, and most tragically, nearly 45,000 deaths every year are associated with a lack of health insurance. Andrew P. Wilper *et al*., *Health Insurance and Mortality in US Adults*, 99 Am. J. Pub. Health 2289, 2295 (2009). Beyond the terrible human tragedies of these deaths, this figure represents tens of thousands of workers whose productive lives are cut short, often leaving their families without a source of income. By increasing access to lifesaving health insurance, the pre-existing conditions provision would prevent many of these tragic deaths, removing a substantial burden on interstate commerce.

CONCLUSION

Amici respectfully submit that the Court should **AFFIRM** the decision of the district court dismissing the case for lack of subject matter jurisdiction. Should the Court reach the merits, however, *amici* submits that, for the foregoing reasons, the ACA falls squarely within Congress' authority.

Dated: August 17, 2011

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32(A)

Pursuant to Fed. R. App. P. 32(a), the attached *amici* brief is proportionally spaced, has a typeface of 14 points or more and contains 4,872 words. The word processing system software used to prepare this brief was Microsoft Word 2007.

CERTIFICATE OF COMPLIANCE WITH CIRCUIT RULE 28A

Pursuant to Circuit Rule 28A(h), the electronic version of this brief is in Portable Document Format, and was generated by printing to PDF from the original word processing file. This brief has been scanned for viruses and is virus free.

/s/ Rochelle Bobroff
Rochelle Bobroff
Attorney for *Amici Curiae*
August 17, 2011

CERTIFICATE OF SERVICE

I hereby certify that on August 17, 2011, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system.

I certify that for all participants in the case who are registered CM/ECF users, service will be accomplished by the appellate CM/ECF system. The foregoing document was served through first class mail to:

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