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# Virginia v. Sebelius - Governor of Washington Amicus Brief

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*State of Washington*

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Nos. 11-1057 & 11-1058

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**IN THE UNITED STATES COURT OF APPEALS  
FOR THE FOURTH CIRCUIT**

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COMMONWEALTH OF VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II,  
in his official capacity as Attorney General of Virginia,

Plaintiff-Appellee/Cross-Appellant,

v.

KATHLEEN SEBELIUS, Secretary of the Department of Health and Human  
Services, in her official capacity,

Defendant-Appellant/Cross-Appellee.

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

---

**AMICUS BRIEF OF THE GOVERNOR OF WASHINGTON  
IN SUPPORT OF APPELLANT, SECRETARY SEBELIUS**

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## I. INTRODUCTION

The Governor of Washington, Christine Gregoire, supports the federal reforms embodied in the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (collectively, “ACA” or the “Act”).<sup>1</sup> Governor Gregoire believes the minimum essential 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 goods and services, in particular by individuals who are now uninsured.

For years, Governor Gregoire and State administrations before hers have grappled with the growing problem of availability of affordable health care for state residents, agencies, and public employees, and the threats that rising health care costs pose to the economic vitality of the State. Given the huge 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 and more effective solution than the states would be able to implement on their own. The Governor actively participated in the political process that led to passage of the Act and believes the Act is a reasonable and necessary response to these shared state and federal goals.

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<sup>1</sup> Counsel for the parties have consented to the filing of this amicus brief.

More specific to the issues in this case, the experiences of Washington State exemplify: (a) the increased costs to states and employers of health care for the uninsured, almost all of whom consume health care resources; (b) the ineffectiveness of critically needed insurance reforms in the absence of minimum coverage requirements; (c) the interstate dimensions of the problem of the uninsured; and, by extension, (d) the constitutionality of the Act's minimum coverage provision. As home to a leading regional trauma center, Washington has unique experience with the phenomenon of interstate travel by the uninsured to obtain medical care and the financial burdens that this interstate mobility places on the economy and institutions of the State. Similarly, Washington knows firsthand the necessity of universal coverage because of the problems it experienced when it eliminated barriers to insurance coverage, like preexisting condition restrictions, without also imposing a minimum coverage requirement. It is on the strength of these experiences that Governor Gregoire supports the minimum coverage provision in the Act and concurs in its constitutionality.

## **II. 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 services and health insurance, including programs that provide insurance, services, or prescription drugs to low-income residents,

state employees, injured workers, and prisoners in the state corrections system. 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.<sup>2</sup>

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-funded Basic Health program, which provides subsidized coverage for low-income, childless adults who typically do not qualify for Medicaid.<sup>3</sup> Approximately 140,000 citizens who want to access Basic Health coverage cannot, due to State budget constraints.<sup>4</sup> Studies project that shortfalls in

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<sup>2</sup> 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](http://www.researchcouncil.org/docs/PDF/WASHACEBusinessClimate/TheHCSpendingSqueeze.pdf)).

<sup>3</sup> Because of budget shortfalls, the Governor was forced to propose elimination of this program. While not yet acting on this proposal, the Legislature recently moved to reduce enrollment by 17,000. Further reductions, or complete elimination, will only exacerbate the problem of the uninsured in Washington and add to the need for a federal solution.

<sup>4</sup> The problems experienced by this program illustrate why the Governor advocated for specific provisions in the ACA to meet state needs. Governor Gregoire worked with Washington's Congressional delegation to amend the legislation to allow states to accelerate extension of Medicaid benefits to childless adults under the Act, providing an opportunity to substitute federal dollars for state funding of existing programs like Basic Health. *See* ACA § 2001(a)(4).

state programs to cover the uninsured such as Basic Health would only worsen in the absence of national health care reform.<sup>5</sup>

The high cost of health insurance, resulting in part from cost-shifting to pay for care for the uninsured, also has negatively impacted economic growth in the State and the ability to participate effectively in interstate and international commerce. A 2009 report by Washington's Insurance Commissioner estimates that each family in Washington pays an additional \$917 per year in medical bills to help cover the costs of the uninsured.<sup>6</sup> This figure is likely to rise as the proportion of the population without insurance increases. At the time of the study, 12 percent of Washingtonians were uninsured; by the end of this year, that figure is expected to reach 14.6 percent. Among working-age adults (ages 19-64), the figure is expected to be 21 percent by the end of 2011. Likewise, the cost of uncompensated care in Washington in 2009 and 2010 was projected to rise by 19% and 12%, respectively.<sup>7</sup>

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<sup>5</sup> 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>).

<sup>6</sup> 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](http://www.insurance.wa.gov/publications/agency_reports.shtml)) ("OIC Report").

<sup>7</sup> *Id.* at 4.

As an inevitable result, the cost to employers of health benefits for their employees has risen apace: premiums rose approximately 38-40% between 2003 and 2009.<sup>8</sup> 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.<sup>9</sup> For example, Washington's closest competitors and trading partners include Canada and Japan.<sup>10</sup> Both have *per capita* expenditures on health care less than half those borne by businesses and workers in the United States.<sup>11</sup> Compared to France, Germany, and England, home to Airbus, the main competitor of Boeing, Washington's largest exporter, America's *per capita* health care costs range between 73% and 110% higher.<sup>12</sup>

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

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<sup>8</sup> Schoen, *et al.*, The Commonwealth Fund, *State Trends in Premiums & Deductibles, 2003-2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs & Eroding Benefits* (December 2010), at 15 (<http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Dec/State-Trends-Premiums-and-Deductibles.aspx>).

<sup>9</sup> Business Round Table, *Trade Creates Jobs for Washington* (January 1, 2010) (<http://businessroundtable.org/studies-and-reports/trade-creates-jobs-for-washington/>).

<sup>10</sup> *Id.*

<sup>11</sup> [http://conversations.psu.edu/docs/calkins\\_comparison.pdf](http://conversations.psu.edu/docs/calkins_comparison.pdf) (viewed January 20, 2011) (presenting 2007 World Health Organization data).

<sup>12</sup> *Id.*

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' share of health care costs as a result of unpredictable rate spikes in the small group markets.<sup>13</sup>

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 in numerous ways, including: the shifting of costs through increased premiums paid by the State as an employer; 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 increased burdens on emergency responders, public health departments, and other social service systems funded by the State.

### **III. 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

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<sup>13</sup> OIC Report, at 4; Washington State Employment Security Department, *2008 Washington State Employee Benefits Survey* (March 2009), at 5-7 (<http://www.workforceexplorer.com/cgi/career/?PAGEID=188>).

many whose health care is now 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 through, *inter alia*, disease prevention and chronic disease management that would be more accessible to low-income individuals and lead to better outcomes. The Act is a product of the political dynamic in the federal system, in which the federal government 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 in an attempt to address the problems of health care costs, access to care, and affordable insurance, with the concomitant effect of reducing expenditures on care for the uninsured. For example, Governor Gregoire's Blue Ribbon Commission on Health Care Costs and Access led to a number of major initiatives, including support for a "medical home" model of coordinated care, with financial incentives linked to improving health outcomes, rather than the number of procedures performed. Through a

health insurance partnership program, Washington has designed the infrastructure for an insurance exchange that would provide assistance to small employers in covering employees who would otherwise go uninsured. The Puget Sound Health Alliance, with the support of the State, is a national leader in identifying and disseminating evidence-based best practices, particularly in the area of disease prevention and chronic disease management. And the State 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 of the ACA's provisions parallel and complement aspects of state programs and initiatives, including in the areas of managed care, information technology, 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 provisions. 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* ACA § 2401(k).

This provision was based on Washington's experience with such rebalancing.<sup>14</sup> The policy choices embodied in the Act, including the provisions on universal coverage and funding for developing less costly and 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.

**IV. 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. Indeed, she 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, or at more expensive levels of care than necessary because of the unavailability of primary care, or at state-funded trauma

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<sup>14</sup> Press Release of Senator Cantwell, *Cantwell Moves to Increase Quality of Health Care While Reducing Costs* (June 12, 2009) (<http://cantwell.senate.gov/news/record.cfm?id=314410>).

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.

**A. Washington’s Experience With Insurance Reform In The Absence of Universal Coverage Underscores The Need For The Minimum Coverage Provision.**

The Governor’s support of the ACA is informed by Washington’s attempt to implement insurance reforms in the absence of an individual mandate. 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; WAC 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.

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.<sup>15</sup> 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 in the insurance market:

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”).

Washington’s experience demonstrates that the ACA’s minimum coverage provision is a necessary and proper adjunct to other reforms of the insurance market. 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 builds on the experience of Washington and similar experiences in other states to avoid the consequences that doomed the state reform initiatives.

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<sup>15</sup> See also Washington Research Council, *Some Gains for Business in 2000 Session*, Policy Brief 00-2 (May 15, 2000), at 3-4 ([www.researchcouncil.org/docs/PDF/WRCBusinessClimate/SomeGains4Bus2000.pdf](http://www.researchcouncil.org/docs/PDF/WRCBusinessClimate/SomeGains4Bus2000.pdf)).

**B. The Uninsured Engage In The Health Care Market And Their Transactions In That Market Result In Significant Economic Burdens To The State.**

The Commonwealth has portrayed the individual minimum coverage provision as forcing activity on citizens who choose to stay out of the marketplace. However, as Congress could reasonably conclude, the need for health care at some stage of life is an almost universal condition of existence and is often unpredictable.<sup>16</sup>

At the outset of life, 99% of all births in the United States take place in a hospital.<sup>17</sup> Thus, virtually every citizen of every state, including Washington,

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<sup>16</sup> The Governor agrees with the federal defendants that the choice of how to pay for health care is not “inactivity.” However, even if it were to be considered inactivity, the Governor does not believe that the federal government is always without power to regulate “inactivity” when necessary for the health and safety of the nation. For example, if there were a nationwide spread of a pandemic disease causing disruption of interstate commerce, like the Spanish flu of 1918, which each state lacked the capacity to address on its own, the Governor believes that Congress would have authority under the Interstate Commerce Clause to impose such measures as vaccination and screening on a universal 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....”). 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.

<sup>17</sup> Martin, *et al.*, Centers for Disease Control & Prevention, *Births: Final Data for 2008*, National Vital Statistics Reports 59(1):17 (Dec. 2010) ([www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59\\_01.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf)).

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.<sup>18</sup> For example, 91.5% of the population 65 and over has been diagnosed with a chronic condition such as diabetes, hypertension or cancer.<sup>19</sup> 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.<sup>20</sup> Given these rates of health care consumption at the beginning and end of life, it is clear that virtually 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.<sup>21</sup> Adults who delay

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<sup>18</sup> 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](http://www.ahrq.gov/clinic/epcsums/eolsum.pdf)).

<sup>19</sup> Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey, Statistical Brief # 203*, p. 1.

<sup>20</sup> <http://hscdataonline.s-3.com/hhsurvey.asp> (viewed January 20, 2011).

<sup>21</sup> Institute of Medicine, *America's Uninsured Crisis; Consequences for Health and Health Care* (2009), at 71 ("IOM Report"); Bindman *et al.*, *Medicaid Re-*

care for chronic conditions such as high blood pressure are at higher risk of developing strokes requiring lengthy hospital stays.<sup>22</sup> 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 the Commonwealth characterizes 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, yet children have no control over their insurance status. Further, the need for 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.<sup>23</sup> People do not plan to get cancer; when they do,

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*Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions*, 46 *Medical Care* 1049, 1052-54 (2008).

<sup>22</sup> Shen & Washington, *Disparities in Outcomes Among Patients With Stroke Associated With Insurance Status*, 38 *Stroke* 1010-1016 (2007).

<sup>23</sup> 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).

the cost of chemotherapeutic drugs can be very substantial.<sup>24</sup> Perhaps the most dramatic examples of unplanned use of health care resources result from automobile crashes, gunshot wounds, falls, and other accidents. 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.<sup>25</sup> The Commonwealth does not explain what it would have trauma centers do when uninsured persons present as trauma victims; would it advocate they be refused treatment because they made the decision not to buy health insurance?

To turn 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 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) (“Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as

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<sup>24</sup> Meropol, *et al.*, *Cost of Cancer Care: Issues and Implications*, 25 J. Clin. Oncol. 180, 182 (2007).

<sup>25</sup> 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](http://www.traumafoundation.org/restricted/tinymce/jscripts/tiny_mce/plugins/filemanager/files/About%20Trauma%20Care_Golden%20Hour.pdf)).

required by State or Federal law, including section 1867 of the Social Security Act (popularly known as EMTALA).”).

Like other Level I trauma centers in states with organized trauma systems, Harborview Medical Center, the Level I center in Washington, takes all trauma patients transferred to it regardless of ability to pay.<sup>26</sup> State and federal funding covers a substantial portion of the cost of care for the 18% of trauma patients who are uninsured—but not all. Nationwide, reimbursement for trauma care is only 50% for self-pay patients.<sup>27</sup> 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.

According to the National Foundation for Trauma Care, the per-patient cost for care in a trauma center is \$14,896.<sup>28</sup> Figures for Washington’s Level I trauma 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.<sup>29</sup> It was reasonable for Congress to infer that individuals who choose not to purchase

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<sup>26</sup> National Foundation for Trauma Care, *U.S. Trauma Center Crisis* (May 2004), at 9 ([www.traumafoundation.org/publications.htm](http://www.traumafoundation.org/publications.htm)). Level I centers provide the highest level of trauma care.

<sup>27</sup> *Id.* at 4, 10 (also reporting that only 8% of the costs of caring for the uninsured are recovered by trauma centers).

<sup>28</sup> *U.S. Trauma Center Crisis*, *supra*, at 4.

<sup>29</sup> <http://hrsa.dshs.wa.gov/HospitalPymt/Trauma/RateFiles/TraumaClaims/1stQtr2011ClaimsDetail.pdf> (viewed March 4, 2011).

minimum coverage, especially on the basis of alleged economic hardship, would not be able to afford the cost of such unexpected care.<sup>30</sup> Under the pre-ACA system, if uninsured individuals get in an accident, develop cancer, or have 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” the Commonwealth seeks to protect, are receiving a benefit—maintenance of a trauma 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.

Congress inescapably, and certainly reasonably, could have found that continuation of such a situation, where uninsured individuals are afforded access to care without contributing to its costs, would increase health 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). It was well within Congress’s constitutional authority to prevent such interference with interstate commerce. *Gonzales v.*

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<sup>30</sup> 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 purchasing coverage pales in comparison to the potential cost for trauma care. For example, the non-partisan Congressional Research Service has calculated 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. *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.

*Raich*, 545 U.S. 1, 19 (2005) (concluding that 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, in *South-Eastern Underwriters*, the Supreme Court confirmed 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 ten years ago well illustrates, such a system cannot work 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*, 130 S. Ct. 1949 (2010). The United States Constitution, as interpreted by the 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.

While much of the argument has focused on local economic activity and its effect on interstate commerce, it is important to note that the uninsured and underinsured also cross state lines to obtain care. For example, many uninsured individuals, who often utilize hospital emergency departments as their primary care provider,<sup>31</sup> 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 emergency room visits to WVUH each year, *West Virginia Univ. Hosps., Inc. v. Rendell*, 2007 WL 3274409, \*2 (M.D. Pa. Nov. 5, 2007). West Virginia calculated that for fiscal year 2007 alone, the Commonwealth owed over \$820,000 in payments for such visits to WVUH. *Rendell*, 2009 WL 3241849, \*6.

Similarly, Harborview Medical Center in Seattle, 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. In 2009, Harborview cared for

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<sup>31</sup> Peppe, *et al.*, Kaiser Family Foundation, *Characteristics of Frequent Emergency Dep’t Users* (Oct. 2007), at 7, 17 ([www.kff.org/insurance/upload/7696.pdf](http://www.kff.org/insurance/upload/7696.pdf)).

12,028 patients from states in the region outside of Washington.<sup>32</sup> 10% of patients from Alaska and Montana and 6% from Idaho were uninsured. Many more were on Medicaid, which pays only a portion of the cost of hospital care.<sup>33</sup> In the last five years, Idaho alone has paid Harborview \$8,658,000 for uninsured and Medicaid patients from that state who received care.<sup>34</sup> Nor is Harborview's experience an isolated example. 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."<sup>35</sup>

Uninsured individuals have a dramatic impact on interstate commerce regardless of whether they receive treatment within their own or another state. These examples merely demonstrate that it is unrealistic to suppose that each state can address these economic impacts on a state-by-state basis. The reality is quite different: a health care network where 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

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<sup>32</sup> Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request, June 2010 (copy available upon request).

<sup>33</sup> *U.S. Trauma Center Crisis, supra*, at 10.

<sup>34</sup> Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request (December 2010) (copy available upon request).

<sup>35</sup> *U.S. Trauma Center Crisis, supra*, at 10.

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 Costs Of Caring 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.<sup>36</sup> Untreated or undertreated hypertension and diabetes are more likely to result in stroke, leading to hospitalization.<sup>37</sup> Stroke victims who did not receive adequate treatment for their underlying conditions are also more likely to suffer neurologic impairment following a stroke.<sup>38</sup> Many individuals with neurologic impairment require long-term care in skilled nursing facilities or adult family homes.<sup>39</sup> For those without private insurance, a substantial portion of the

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<sup>36</sup> IOM Report, *supra*, at 74-75 ; OIC Report, *supra*, at 7.

<sup>37</sup> IOM Report, *supra*, at 76.

<sup>38</sup> *Id.*

<sup>39</sup> Rundek, *et al.*, "Predictors of resource use after acute hospitalization: the Northern Manhattan Stroke Study," *55 Neurology* 1180, 1184-85 (October 2000).

cost of such care frequently falls to the State under Medicaid or solely State-funded safety net programs.<sup>40</sup>

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 more effective care earlier in the course of their diseases.<sup>41</sup> The minimum coverage requirement under the ACA, which includes coverage for preventive and chronic disease care, *see* ACA §§ 1201, 1302(I), 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. There, pre-Medicare-eligible (*i.e.*, under 65) employees and spouses with severe chronic diseases were enrolled in a “medical home.” The medical homes, based in three different primary care clinics, provided intensive outpatient care, extensive evaluation, screening and diagnostic

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<sup>40</sup> 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](http://www.americanprogress.org/issues/2010/12/pdf/dual-eligibles.pdf)).

<sup>41</sup> McWilliams, “Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications,” 87 *Millbank Quarterly* 443, 476 (June 2009)

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.<sup>42</sup>

King County, the most populous county in the State, also 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.<sup>43</sup> The County is supporting clinics in taking a comprehensive approach to these patients, including the use of case managers and home visits to educate patients in self-management of their conditions. This project is currently supported by a Medicaid grant, but could be carried forward and made available to other low-income individuals if they had insurance.

The Governor has a strong interest in seeing that the consumption of health care services by individuals with severe chronic disease can occur 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

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<sup>42</sup> <http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable> (viewed January 20, 2011).

<sup>43</sup> *King County Steps to Health*, <http://www.kingcounty.gov/healthservices/health/chronic/steps.aspx> (viewed January 20, 2011).

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.<sup>44</sup> In FY2007 in Washington, over 109,000 individuals were eligible for Medicare, but still required state funding for coverage of long-term care needs.<sup>45</sup> In the 2007-09 biennium, the State spent over \$3 billion on care for such individuals who did not have private long-term care insurance.<sup>46</sup> 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 of children are also afflicted with chronic illness, including asthma, persistent ear infections, allergies, and diabetes.<sup>47</sup> National studies have shown that access to preventive and primary care reduces hospital admissions for such conditions, which can be more effectively treated in the outpatient setting if

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<sup>44</sup> See [www.medicare.gov/longtermcare/static/home.asp](http://www.medicare.gov/longtermcare/static/home.asp) (“Generally, Medicare doesn’t pay for long-term care.”) (viewed January 20, 2011).

<sup>45</sup> See Rousseau, *et al.*, Kaiser Commission on Medicaid & the Uninsured, *Dual Eligibles: Medicaid Enrollment & Spending for Medicare Beneficiaries in 2007* (December 2010), at 5 ([www.kff.org/medicaid/upload/7846-02.pdf](http://www.kff.org/medicaid/upload/7846-02.pdf)). 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.*

<sup>46</sup> See [www.aasa.dhs.wa.gov/about/slideshows/Introduction%20to%20ADSA.pdf](http://www.aasa.dhs.wa.gov/about/slideshows/Introduction%20to%20ADSA.pdf) (viewed January 20, 2011).

<sup>47</sup> Institute of Medicine, *America’s Children: Health Insurance and Access to Care* (1998), 120.

caught early and addressed by a continuous source of care.<sup>48</sup> The cost in Washington of the average 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.<sup>49</sup>

Washington's Apple Health for Kids program, created in 2008, streamlines enrollment for children in state-administered insurance plans, including Medicaid, the State Children's Health Insurance Program ("SCHIP"), and the Children's Health Program.<sup>50</sup> 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.<sup>51</sup> 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

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<sup>48</sup> 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 *Pediatrics* 738-42 (1999); The Baker Institute Policy Report, *The Economic Impact of Uninsured Children on America* (2009), at 4, 5.

<sup>49</sup> <http://www.childrensalliance.org/resource-center/fact-sheet-federal-bonus-apple-health-kids> (viewed March 4, 2011); Jonathan Seib, Executive Policy Advisor, Governor of Washington's Executive Policy Office (email comm. March 7, 2011).

<sup>50</sup> <http://hrsa.dshs.wa.gov/applehealth/> (viewed March 4, 2011)

<sup>51</sup> <http://www.childrensalliance.org/resource-center/fact-sheet-federal-bonus-apple-health-kids> (viewed March 4, 2011)

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.<sup>52</sup>

**E. The Minimum Coverage Provision Is A Necessary And Reasonable Measure To Address The Economic And Other Effects Created By Consumption Of Care By The Uninsured.**

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 almost \$700 million in 2008.<sup>53</sup> 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*, - F.3d -, 2011 WL 477072, at \*3 & n.4 (9<sup>th</sup> Cir. Feb. 11, 2011) (describing the State's subsidization of hospital care for the uninsured).

As explained above, these costs are exacerbated because many individuals without insurance delay care until their conditions become more acute and more

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<sup>52</sup> *Id.*

<sup>53</sup> OIC Report, *supra*, at 2.

expensive to treat.<sup>54</sup> See *University of Washington Medical Center, supra*, at \*1 n.2. The uninsured also are more likely to be frequent users of and to obtain a greater proportion of their medical care from emergency departments, the most expensive level of care, than those with private insurance.<sup>55</sup> State subsidies to hospitals with large numbers of such patients are provided through the “disproportionate share” program (“DSH”) of federal-state payments to such hospitals. See *University of Washington Medical Center, supra* (describing operation of DSH payments). The cost of these payments to the State is substantial: in Washington, total DSH payments to hospitals were \$326 million in FY2008.<sup>56</sup> 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 \$155,174,000 in 2009, of which only a portion is offset by DSH payments.<sup>57</sup>

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<sup>54</sup> Kaiser Comm’n for Medicaid & the Uninsured, *Low-Income Adults Under Age 65* (June 2009), at 12 (<http://www.kff.org/healthreform/upload/7914.pdf>); IOM Report, *supra*, at 5-8, 57-83.

<sup>55</sup> *Peppe, et al., supra*, 7, 17.

<sup>56</sup> [www.statehealthfacts.org/profileglance.jsp?rgn.49](http://www.statehealthfacts.org/profileglance.jsp?rgn.49) (viewed Jan. 20, 2011).

<sup>57</sup> Washington State Dep’t of Health, *Washington State 2000 Charity Care in Washington Hospitals* (July 2002), at 10 (<http://www.doh.wa.gov/EHSPHL/hospdata/CharityCare/Reports/2000CharityCareinWashingtonState.doc>); Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request, June 2010.

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 uninsured are less likely to have a regular care provider to go to when sick, and experience more difficulty accessing specialty and emergency room care, than individuals in communities where more people are insured.<sup>58</sup> 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.<sup>59</sup>

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

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<sup>58</sup> Pauly & Pagan, *Spillovers and Vulnerability: The Case of Community Uninsurance*, 26 Health Affairs 1304, 1309-10 (2007).

<sup>59</sup> *Id.*

uninsured, as well as other patients, by reducing their need for and reliance on urgent 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.

Families and businesses who purchase insurance also shoulder the burden of a system that cares for the uninsured in settings that do not provide the preventive or follow-up care that would reduce costs, while providing better care. As mentioned above, each insured family in Washington pays an estimated \$917 per year more in medical bills to help defray the cost of caring for the uninsured.<sup>60</sup> 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.<sup>61</sup> In 2009, 1.2 million insured Washingtonians spent more than 10% of their pre-tax income on health care.<sup>62</sup> 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. According to the Washington Insurance Commissioner, the determining factor in whether a person has insurance is their income level, *i.e.*,

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<sup>60</sup> OIC Report, *supra*, at 1.

<sup>61</sup> [www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=5&rgn=49&ind=595&sub=143](http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=5&rgn=49&ind=595&sub=143) (viewed January 20, 2011).

<sup>62</sup> OIC Report, *supra*, at 9.

whether they can afford the high cost of insurance.<sup>63</sup> While 76% of employers in Washington insured their full-time employees in 2003, by 2008, only 56.5% of firms did.<sup>64</sup>

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. 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.

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. Without the minimum coverage and related insurance reforms under the ACA, Washington State and its health care providers would be forced to bear ever greater costs of treatment for uninsured

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<sup>63</sup> *Id.* at 5.

<sup>64</sup> Washington State Employment Security Dep't, *2003 Employee Benefits Survey*, at 8 (March 2004) and *2008 Washington State Employee Benefits Survey*, *supra*, at 5.

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

## V. CONCLUSION

For the reasons stated above, the Governor of Washington believes the ACA's minimum essential 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.

DATED: March 7, 2011. s/ Kristin Houser

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## CERTIFICATE OF COMPLIANCE

As counsel for *amici curiae*, I certify pursuant to Federal Rule of Appellate Procedure 32(a)(7)(c) that the foregoing brief is in 14-point, proportionately spaced Times New Roman font. According to the word processing software used to prepare this brief (Microsoft Word), the word count of the brief is exactly 6996 words, excluding the cover, corporate disclosure statement, table of contents, table of authorities, certificate of service, and this certificate of compliance.

*s/ Kristin Houser*

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**CERTIFICATE OF SERVICE**

As counsel for *amicus curiae*, I hereby certify that on this 7<sup>th</sup> day of March, I electronically filed the foregoing Brief with the Clerk of the Court for the U.S. Court of Appeals for the Fourth Circuit by using the appellate CM/ECF system. The ECF system will automatically generate and send by e-mail a Notice of Docket Activity (NDA) to all registered attorneys participating in the case, which notice constitutes service on those registered attorneys.

*s/ Kristin Houser*

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