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Thomas More Law Center v. Obama - Amicus Brief of Governor Gregoire

Christine Gregoire
Office of the Governor of the State of Washington

No. 10-2388

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

THOMAS MORE LAW CENTER; JANN DEMARS; JOHN CECI;
STEVEN HYDER; & SALINA HYDER,

Plaintiffs-Appellants,

v.

BARACK HUSSEIN OBAMA, IN HIS OFFICIAL CAPACITY AS
PRESIDENT OF THE UNITED STATES, ET AL.

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Michigan
Honorable George Caram Steeh
Civil Case No. 10-11156

AMICUS BRIEF ON BEHALF OF THE GOVERNOR OF WASHINGTON IN SUPPORT OF AFFIRMANCE

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I. INTRODUCTION

The Governor of Washington, Christine O. Gregoire, supports the federal reforms embodied in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "ACA" or the "Act"). Governor Gregoire believes the minimum coverage provisions are an appropriate use of federal power under the Interstate Commerce Clause of the United States Constitution 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 administrations before hers have grappled with growing problems of the availability of affordable health care for state residents, state 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 that the Act is a reasonable and necessary response to these shared state and federal goals.

More specific to the issues in this case, the experiences of Washington State exemplify: (a) the increased costs to the states 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 an individual mandate; (c) the interstate dimensions of the problem of the uninsured; and, by extension, (d) the constitutionality of the minimum coverage provisions included in the Act. 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 placed on the economy and institutions of the State by such travel. Similarly, Washington knows firsthand the necessity of universal coverage because of the problems this state 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 provisions in the Act and concurs in its constitutionality.

II. WASHINGTON'S STATE BUDGET AND ECONOMY HAVE SUFFERED AS A RESULT OF SPIRALING HEALTH CARE AND HEALTH 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.[1]

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 a state-only program, the Basic Health program, established to provide subsidized coverage for low-income adults without children who typically do not qualify for Medicaid.[2] More than 140,000 citizens who want to access Basic Health coverage cannot, due to state budget constraints.[3] Studies project that

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[1] *See* 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).

[2] Because of financial problems, the Governor has been forced to propose elimination of this program. The Legislature has not yet acted on this proposal; if enacted, it will only exacerbate the problem of the uninsured in Washington State and add to the need for a federal solution.

[3] This program illustrates 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 afford states the opportunity 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).

shortfalls in state programs to cover the uninsured such as this would only worsen in the absence of national health care reform.[4]

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 its ability to participate effectively in interstate and international commerce. A 2009 report by Washington's Insurance Commissioner estimated that each family in Washington pays an additional $917 per year in medical bills to help cover the costs of the uninsured.[5] This figure is likely to rise steadily as the proportion of the population without insurance rises. At the time of the study, the percentage of uninsured in Washington was 12 percent; by the end of this year, it is expected to reach 14.6 percent of Washingtonians. Among working-age adults (ages 19-64), the figure is expected to be 21 percent by the end of 2011. Although the figures are not in yet, the cost of uncompensated care in Washington in 2009 and 2010 was projected to rise by 19% and 12%, respectively. *Id.* at 4.

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

[5] 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), p. 3 (http://www.insurance.wa.gov/publications/agency_reports.shtml) (hereinafter "OIC Report").

As an inevitable result, the cost to employers of health benefits for their employees have risen apace: premiums rose approximately 38-40% between 2003 and 2009.[6] In a state like Washington, in which more than 20% of jobs derive from international trade, there is reason for grave concern that its businesses will be increasingly unable to compete in the international economy.[7] Uncontrolled health care costs, in part due to the high cost of uncompensated care, and care being delivered in more expensive hospital settings to uninsured individuals without access to primary 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' share of health care costs as a result of

[6] *See* Schoen, Cathy, 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).

[7] *See* Business Round Table, *Trade Creates Jobs for Washington* (January 1, 2010) (http://businessroundtable.org/studies-and-reports/trade-creates-jobs-for-washington/). Washington's closest competitors/trading partners include Canada and Japan. *Id.* Both have per capita expenditures on health care that are less than half those borne by businesses and workers in the United States. *See* http://conversations.psu.edu/docs/calkins_comparison.pdf (viewed January 20, 2011) (presenting 2007 World Health Organization data). Compared to France, Germany, and England, home to the main competitor of Boeing, Washington's largest exporter, America's per capita health care cost ranges between 73% and 110% higher. *Id.*

unpredictable rate spikes in the small group markets.[8] 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 longterm care for the disabled and elderly who are uninsured for this form of health care, which is borne in substantial part by the state; 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 many whose health care is now wholly funded by the states, increase competition and affordability in the insurance market, and fund efforts to change health care delivery models and control spiraling costs. Governor Gregoire advocated federal action to reform the nation's health care system with a focus on delivery models

[8] OIC Report, p. 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).

that would provide less costly care through, *inter alia*, disease prevention and chronic disease management, which 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 simply 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 important 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 state has designed the infrastructure for a health insurance exchange for small employers that would provide these employers assistance 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 currently has its Basic Health program whose purpose is to offer affordable health coverage to low-income families and individuals in Washington state, *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, indigent adults. The Act clearly 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 includes provisions that create 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 language was based on the experience in Washington

with such rebalancing.[9] 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 PROVISIONS ARE A NECESSARY AND PROPER EXERCISE OF FEDERAL POWER UNDER THE INTERSTATE COMMERCE CLAUSE TO ADDRESS INTERSTATE ECONOMIC PROBLEMS, INCLUDING THE COSTS OF THE UNINSURED, WHICH CANNOT BE SOLVED BY A STATE ACTING ALONE

The Governor supports the minimum coverage provisions of the ACA; indeed, she believes those provisions 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 as well. 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 centers when they suffer injury from accident or stroke or other

[9] *See* 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).

unpredictable catastrophic events, must be addressed by a federal regulatory scheme that rationalizes payment and aligns payment incentives with less expensive, more effective care. As Washington's experience shows, the minimum coverage provisions are 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 Provisions.

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 has 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 which attempted similar reforms, as described in the appellees' brief, at 38-39, 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.[10] 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).

Washington's experience demonstrates that the ACA's minimum coverage provisions are a necessary and proper adjunct to other reforms of the insurance market. Without the universal mandate, 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's minimum coverage requirement 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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[10] *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).

B. The Uninsured Engage in Economic Transactions Regarding Their Health Care That Result in Significant Burdens to the State.

Plaintiffs have portrayed the minimum coverage provisions as forcing activity on citizens who are merely "living" or "breathing." Appellants' Brief, 11-19, 29-32. Plaintiffs' *reductio ad absurdum* argument ignores the clear import of the district court's decision; as the district court recognized, the need for health care at some stage of life is an almost universal condition of existence.[11] At the outset of life, 99% of all births in the United States take place in a hospital.[12] Thus, virtually every citizen of every state, including Washington, starts out as a

[11]The Governor agrees with the federal appellees that the choice of how to pay for health care is not "inactivity," as explained at pages 45-52 of the Brief of the Appellees in this case. 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 and hopes that Congress would have authority under the Interstate Commerce Clause to impose such measures as vaccination and screening of people on a universal basis, even with penalties for noncompliance far exceeding the fine that is the only consequence of refusing to buy insurance under the Act. *See* 42 U.S.C. 264; 42 CFR 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….").

[12] *See* Martin, Joyce, *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).

consumer of health care. The Governor has a legitimate concern as to how such acts of consumption are paid for, particularly as to the uninsured portion of the population. When lack of coverage results in inadequate care, apart from the health consequences, she also has a significant additional concern as to the resulting future consumption of costly health care resources.. For example, uninsured children with serious health conditions that are not diagnosed early in life are more likely to incur avoidable hospitalizations.[13]

At the other end of life, people are living longer with chronic conditions that typically result in the utilization of health care resources.[14] For example, 91.5% of the population 65 and over has been diagnosed with a chronic condition such as diabetes, hypertension or cancer.[15] 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.[16] Given these rates of consumption of health care at the beginning and end of life, it is clear that, as the district court found, virtually no one is exempt from participation the health care market.

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[13] Institute of Medicine 2009, *America's Uninsured Crisis; Consequences for Health and Health Care* ("IOM Report"), p.71.

[14] Lorenz, K., *et al.*, Agency for Healthcare Research & Quality, *End-of-Life Care & Outcomes: Summary*, Evidence Report/Technology Assessment No. 110, at 1 (Nov. 2004) (www.ahrq.gov/clinic/epcsums/eolsum.pdf).

[15] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey, Statistical Brief # 203*, p. 1.

[16] http://hscdataonline.s-3.com/hhsurvey.asp (viewed January 20, 2011).

Appellants further have attempted to characterize the use of health care resources by the uninsured as a matter of choice, over which they wish to retain control. However, the need for health care goods and services is frequently unplanned. There are, for example, unplanned births to uninsured individuals. People do not plan to get cancer; when they do, the cost of chemotherapeutic drugs can be very substantial.[17] Perhaps the most dramatic example of the unplanned use of health care resources results from motor vehicle accidents, gunshot wounds, falls, and other accidents. Severely injured accident victims may not be conscious and able to make decisions, yet trauma research demonstrates that care within the first hour (referred to as the "Golden Hour") following injury is critical to survival and recovery.[18] Plaintiffs do not explain what they would have trauma centers do if they, or other uninsured persons, present as trauma victims; would they advocate that they be turned away 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 in the form of the Emergency Medical

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[17] Meropol et al., *Cost of Cancer Care: Issues and Implication*s, 25 J. Clin. Oncol. 180, 182 (2007).

[18] 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) (viewed January 21, 2011).

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 USC §1395dd (b)(1). Like other Level I trauma centers in states with organized trauma systems, Harborview Medical Center, the Level I trauma center in Washington, takes all trauma patients transferred to it regardless of ability to pay.[19] State and federal trauma funding covers a substantial portion of the cost of the care for the 18% of those trauma patients who are uninsured, but not all; nationwide, reimbursement for trauma care is only 64% for Medicaid patients and 50% for self-pay patients such as the individual plaintiffs.[20] The Governor urged the 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.

Plaintiffs DeMars and Hyder aver that to pay the estimated $8,832 cost of the coverage required by the minimum coverage provision in 2014 will be a "hardship" unless they reorganize their personal affairs now. *See* R-18, Exhibit 1

[19] 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.

[20] National Foundation for Trauma Care, *supra* n.19, at 4, 10 (also reporting that only 8% of the costs of caring for the uninsured are recovered by trauma centers).

(Suppl. DeMars Decl.) and R-7, Exhibit 5 (Hyder Decl.).[21] However, according to the National Foundation for Trauma Care, the per patient cost for care in a trauma center is $14,896.[22] Figures for Washington State'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.[23] It is reasonable to infer that individuals such as plaintiffs for whom it would be a hardship to pay the $8,832 cost of insurance, are not going to be able to afford the cost of unexpected trauma care. Under the present system, if individuals with limited means, such as plaintiffs, get in an accident or have a stroke, they receive care, i.e., consume goods and services, and society pays what they cannot.

It was reasonable for Congress to infer that individuals such as plaintiffs who claim it would be a hardship to pay the $8,832 cost of insurance at the rate of $700 a month are not going to be able to afford the cost of such unexpected care.[24]

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[21] Interestingly, these same individual plaintiffs asserted, and the District Court accepted, that this "present financial pressure" that plaintiffs are experiencing was a sufficient "injury-in-fact" to confer standing to challenge the minimum coverage provision. Yet plaintiffs argue at the same time that the economic decision-making regarding whether or not to carry insurance is *not* an act or activity that would trigger the application of the Interstate Commerce Clause.

[22] National Foundation for Trauma Care, *supra* n.19, at 4.

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

[24] Plaintiffs explain that they would be subject to the penalty for not purchasing insurance and logically, therefore, must have income high enough not to be excluded from such penalty payments pursuant to 26 USCA § 5000A.

Under the pre-ACA system, if individuals such as plaintiffs 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.

Individuals who can afford to get a benefit, but are unwilling to pay their fair share of the cost of that benefit, are getting "something for nothing" and the rest of society subsidizes them The current cost of such subsidization in Washington is $917 per family per year. However, that cost likely will grow considerably given that the ACA eliminates insurance companies' right to exclude persons from health insurance or charge higher insurance premiums based upon pre-existing conditions. Plaintiffs do not seek to enjoin those portions of the ACA; thus, if this appeal were successful, plaintiffs would receive all of the benefits of the ACA, but not the burden of paying for minimum coverage – the very provision that makes the benefits possible. The Governor of Washington is acutely aware of the perils of such an arrangement, given Washington's experience with the insurance death spiral; yet plaintiffs' approach would re-create that unworkable scenario. As stated at the conclusion of Appellants' brief at page 52, "Plaintiffs respectfully request that this court reverse the district court, declare the Individual Mandate provision of the Healthcare Reform Act unconstitutional, and enjoin its enforcement." Plaintiffs thus seek a result that would allow them to sign up for

health insurance on the way to the hospital and stop paying premiums as soon as they are feeling better.

Congress inescapably, and certainly reasonably, could have found that plaintiffs' preferred result would increase health costs and interfere with the viability of health insurance, which are part of interstate commerce. *See* 42 U.S.C.A. §18091 (a)(2)(H)-(J). It was well within Congress's constitutional authority to prevent such interference with interstate commerce. *Gonzales v. 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"); *United States v. Comstock*, 130 S. Ct. 1949 (2010). The Governor wholly endorses Congress's effort to craft a balanced approach which maximizes the chances of a successful result for citizens of the State of Washington. 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, 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 12,028 patients from states in the region outside of Washington.[25] 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.[26] In the last five years, Idaho alone has paid Harborview $8,658,000 for uninsured and

[25] Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request, June 2010 (copy available upon request).
[26] *See* National Foundation for Trauma Care, *supra* n.19, at 10.

Medicaid patients from that state who received care.[27] 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."[28]

Certainly uninsured individuals have a dramatic impact on interstate commerce regardless of whether they receive treatment within their own or in 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 geographical distance and specialized medical centers, rather than state borders, are key factors to care and where any person might unexpectedly travel or be transported to another state for care. The magnitude of such activity, involving the consumption of health care goods and 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.

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[27] Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request, December 2010 (copy available upon request).
[28] National Foundation for Trauma Care, *supra* n.19, at 10.

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.[29] Untreated or undertreated hypertension and diabetes are more likely to result in stroke; moreover, stroke victims who did not receive adequate treatment for their underlying conditions are more likely to suffer neurologic impairment following a stroke.[30] Initially, stroke victims require hospital care. Many individuals with neurologic impairment require long-term care in skilled nursing facilities or adult family homes[31]; for those without private insurance, a substantial portion of the cost of such care frequently falls to the State under Medicaid or solely state-funded welfare safety net programs.[32]

Efforts are underway in Washington to intervene in this trajectory of untreated or undertreated chronic disease leading to acute crises requiring expensive care – in addition to the devastation wrought on individual lives.

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[29] IOM Report, *supra* n.13, at 74-75 ; OIC Report, *supra* n. 5, at 7.

[30] IOM Report, *supra* n.13, at 76.

[31] Rundek, Mast, Hartmann,et al., "Predictors of resource use after acute hospitalization: the Northern Manhattan Stroke Study," *Neurology*, October 2000, 55:1180, 1184-85.

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

However, key to the success of these efforts is that individuals have the means to access more effective care earlier in the course of their diseases.[33] Universal coverage would provide the means and, as an inevitable consequence, reduce the burden on the State and its citizens of paying for care when the need becomes the most extreme and the most expensive.

A recent pilot program for Boeing employees with chronic disease shows what is possible if the means are there. In that program, pre-Medicare eligible (i.e., under 65) employees and their spouses who had severe chronic diseases were enrolled in a form of "medical home." This medical home, based in three different primary care clinics, provided intensive outpatient care, including 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%, based mostly on emergency room visits and hospitalizations.[34]

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

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

[34] http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable (viewed January 20, 2011).

income. This population has limited access to primary care, and those with diabetes and asthma are hospitalized for their diseases at twice the rate of those with the same conditions in the rest of the county.[35] The County is supporting clinics in taking a comprehensive approach to these patients, including chronic disease management. 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 those 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 longterm care needs, because Medicare does not cover the cost of such care.[36] In fiscal year 2007 in Washington, over 109,000 individuals were eligible for Medicare, but still required

[35] *King County Steps to Health*, *http://www.kingcounty.gov/healthservices/health/chronic/steps.aspx* (viewed January 20, 2011).

[36] *See* www.medicare.gov/longtermcare/static/home.asp ("Generally, Medicare doesn't pay for long-term care.") (viewed January 20, 2011).

state funding for coverage of their long term care needs.[37]. In the 2007-09 biennium, the State spent over $3 billion on long-term care for such individuals who did not have private long term care insurance.[38] Thus, the State has a strong economic interest in a requirement that residents of the United States carry insurance that covers preventive care and chronic disease management. *See* ACA §§ 1201, 1302(I).

E. The Scope of the Problem of the Uninsured in Washington State Calls for a Federal Solution.

By deciding not to purchase insurance, plaintiffs and others like them are merely shifting the costs of their health care on 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.[39] These costs impose substantial burdens on families and employers, including the states, because of cost-shifting to insured patients, and on the state government,

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[37] See Rousseau, David, *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). These individuals comprise "some of the sickest and poorest patients in our nation's health care system." Davenport, *supra* n.33, at 1. They are often referred to as "dual eligibles" because they are eligible for Medicare by reason of age or disability and for Medicaid on the basis of low income. *Id*.

[38] *See* www.aasa.dhs.wa.gov/about/slideshows/Introduction%20to%20ADSA.pdf (viewed January 20, 2011).

[39] OIC Report, *supra* n.5, at 2.

which provides significant subsidies to hospitals and clinics with large volumes of uninsured patients.

These costs are exacerbated because many individuals without insurance delay care until their conditions become more acute.[40] In addition to the negative health impacts of such delays, acute care and care for more advanced disease is typically more expensive than primary or preventive care.[41] Further, the uninsured 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.[42] State subsidies to hospitals with large numbers of such patients are provided through the "disproportionate share" program ("DSH") of federal-state payments to hospitals that serve large numbers of the uninsured. The cost of payments to the State is substantial: for example, in Washington, total DSH payments to hospitals were $326 million in FY2008.[43] However, despite DSH payments, the volume of uncompensated care is becoming increasingly

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[40] 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* n.13, at 5-8, 57-83.

[41] *Id*.; Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured* (June 2005) , at 12-13 (http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html)..

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

[43] *See* www.statehealthfacts.org/profileglance.jsp?rgn.49 (viewed Jan. 20, 2011).

unsustainable for providers, particularly public safety net hospitals. For example, Harborview has gone 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.[44]

The ACA addresses this issue in two ways: first by promoting universal insurance coverage through the minimum coverage provisions 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, such as those already being implemented in Washington state, through investment and realignment of payor 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 health 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 urgent care services. At the same time, the full impact of these innovations will be realized

[44] 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 (copy available upon request).

only if individuals have the insurance coverage to access such care in the first place.

Families and businesses who offer insurance to their employees 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 is estimated to pay an additional $917 per year in medical bills to help defray the cost of caring for the uninsured.[45] The increases in premiums and health care costs that have occurred, in significant part to pay for the uninsured, are staggering. For example, between 1991 and 2004, health care costs in the State grew at a average rate of 7.3% per year.[46] n 2009, 1.2 million insured Washingtonians spent more than 10% of their pre-tax income on health care.[47] 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 a report by the Washington Insurance Commissioner, the determining factor in whether a person has insurance is their income level, i.e., whether they can afford the high cost of insurance.[48]

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[45] OIC Report, *supra* n.5, at 1.
[46] *See* www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=5&rgn=49&ind=595&sub=143 (viewed January 20, 2011).
[47] OIC Report, *supra* n.5, at 9.
[48] *Id.* at 5.

While 76% of employers in Washington insured their full-time employees in 2003, by 2008, only 56.5% of firms did.[49]

The cost of caring for the uninsured thus 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 people who suffer catastrophic medical events or fail to get preventive care and screening examinations 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 coverage provisions are 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..

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[49] Washington State Employment Security Dep't, *2003 Employee Benefits Survey*, at 8 (March 2004) and *2008 Washington State Employee Benefits Survey, supra* n.8, at 5..

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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 6,598 words, excluding the cover, corporate disclosure statement, table of contents, table of authorities, certificate of service, and this certificate of compliance.

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CERTIFICATE OF SERVICE

As counsel for *amicus curiae*, I hereby certify that on this 21st day of January, 2011, I electronically filed the foregoing Brief with the Clerk of the Court for the U.S. Court of Appeals for the Sixth 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.

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