No. 11-398

IN THE
Supreme Court of the United States

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,

v.

STATE OF FLORIDA, ET AL.,
Respondents.

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

BRIEF OF HEALTH CARE POLICY HISTORY SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS (Minimum Coverage Provision)

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STATEMENT OF INTEREST OF AMICI CURIAE[1]

The Amici Curiae (listed individually by name and title in Appendix A to this brief) are thirty-four scholars who study the history of health care policy in the United States ("Health Care Policy History Scholars"). The Health Care Policy History Scholars come from a variety of academic disciplines, including health policy, health economics, law, and political science, as well as history. All have written books or articles examining the development of health care policy in the United States, and in particular the role of the federal government in shaping health care policy. Several have participated in that policy's development.

The Health Care Policy History Scholars believe that the Eleventh Circuit Court of Appeals' opinion fundamentally mischaracterizes important facts regarding the historical role of the federal government in health care. It is vital for this Court to understand that the role established for the federal government by provisions of the Affordable Care Act ("ACA")—including the minimum coverage requirement—is consistent with, and not different in kind from, the historical role of the federal government in health care.

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[1] No counsel for a party authored this brief in whole or in part and no such counsel or a party made a monetary contribution intended to fund the preparation or submission of this brief. No other person other than the amici curiae or their counsel made such a monetary contribution. All parties have consented to the filing of this brief; letters reflecting their consent have been filed with the Court's Clerk.

SUMMARY OF ARGUMENT

The Eleventh Circuit asserted that the minimum coverage requirement is an "encroachment upon... areas of traditional state concern." *Florida v. U.S. Dep't Health & Human Servs.*, 648 F.3d 1235, 1306 (11th Cir. 2011). It also claimed that the requirement was a "wholly novel...assertion of congressional authority." *Florida*, 648 F.3d at 1328. These statements are inconsistent with the historical facts.

Federal intervention in the nation's health care system is not new, as most federal appellate court judges who have ruled on the constitutionality of the ACA have recognized. *See Seven Sky v. Holder*, 661 F.3d 1, 19 (D.C. Cir. 2011); *Liberty Univ., Inc. v. Geithner*, No. 10-2347, 2011 WL 3962915, at *38 (4th Cir. 2011) (Davis, J., dissenting); *Florida*, 648 F.3d at 1333–36 (Marcus, J., dissenting in part); *Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 544 (6th Cir. 2011). Congress has long intervened to support and regulate the provision of institutional and professional health care in the United States. Congress also has an extensive history of using its constitutional authority to affect the supply of and demand for health insurance and the amount individuals pay for that insurance.

Our modern American health care system has evolved largely in tandem with federal health policy. Although our health care delivery system remains largely private, it would look very different but for the federal support and regulation during the second half of the twentieth century. Federal funding has extended across the delivery system—supporting hospitals, physician and other professional training, and pharmaceutical research. Direct federal spending for health care currently covers 27 percent of national health care spending. Anne Martin et al., *Re-*

cession Contributes to Slowest Rate of Annual Increase in Health Spending in Five Decades, 30 HEALTH AFF. 11, 15 (Jan./Feb. 2011). Those expenditures have historically been accompanied by federal regulation. Indeed, use of federal authority has played a key role in sustaining private health insurance and private health care markets, and continued federal engagement is necessary to sustain them for the future.

Most Americans have access to the health care system because they have insurance to cover the cost of that care. Both private and public insurance coverage became significant forces in the second half of the twentieth century. While the most common way Americans are insured today is through employer-sponsored insurance, which covers 55.3 percent of the population, 31 percent of Americans are covered by public insurance programs. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23 (2011).

Federal support and regulation have played a vital role in the development of this system of health care financing. Federal direct funding for health care for the uninsurable and tax expenditures that support private insurance make the nation's private health insurance system possible. Employer-based coverage has flourished because of federal tax subsidies and regulatory protection. The nation's major public health insurance programs, Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), Veterans and Defense Department programs, the Indian Health Service and federally-qualified community health centers—all funded wholly or in part by the federal government—have covered many Americans who cannot afford private insurance or who are uninsurable.

As described more fully below, federal health care policy has been instrumental in the development of the modern health care system in at least four ways. First, federal support has been vital to the development of the supply side of our health care system, funding hospital construction, medical education, and the research that underlies the development of new drugs and devices. Second, federal support has driven the development of the demand side, both through direct spending via public insurance programs and through tax subsidies that have fostered the provision of private health insurance. Third, federal regulation imposed under the Spending Clause has dramatically changed our health care system, opening the doors of hospitals to individuals regardless of race in the 1960s and to persons undergoing medical emergencies regardless of ability to pay in the 1980s. Finally, federal regulation under the Commerce Clause has long been pervasive, governing employee benefit plans, privacy of medical records, and procedures doctors may use to perform abortions.

State funding and regulation of our health care system, which date back to the nineteenth century, *see* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 102-07 (Basic Books 1982), antedated federal funding and regulation and continue today. In some contexts federal law has totally preempted state law, in some federal and state law coexist, and in a few areas state law remains predominant. It has been decades, however, since one could accurately characterize health care as an area of "traditional state concern"—as opposed to one in which the federal government played a significant role—in anything other than a historical sense. Indeed, federal law has long had a more pervasive in-

fluence on both health care delivery and finance than state law.

While federal funding and regulation have directly or indirectly helped to bring health insurance to the vast majority of Americans, a substantial and, in recent years, growing number of Americans remain uninsured, and increasing numbers of Americans currently insured face the risk of losing coverage. Uninsured Americans regularly receive substantial amounts of health care, much of the cost of which is "shifted" to the federal and state governments or to those persons who have private health insurance—the existence of which flows largely from the federal government's policies. Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFF. w399, w402 (2008).

The ACA seeks to expand access to affordable health insurance through premium tax credits, an expansion of Medicaid and restrictions on health insurers' ability to deny coverage to individuals because of their health status. It also specifically seeks to extend health insurance coverage through the minimum coverage requirement, which encourages uninsured Americans to become insured, often by taking advantage of federal support programs such as Medicaid or premium tax credits.

The minimum coverage requirement seeks to protect Americans who are already insured from bearing the burden of cost-shifting by the uninsured who can afford insurance. It thereby fills a critical gap in the existing scheme of federal statutes and regulations that have already extended health care coverage to most Americans. Seen in the context of the long-standing federal role in getting more Americans

insured, there is nothing "wholly novel" about the minimum coverage requirement.

The way in which the requirement extends coverage—imposing a cost on those who fail to purchase health insurance in a timely manner to provide for their future health needs—is also not "wholly novel." The Medicare program, like the minimum coverage requirement, requires Americans to pay in advance for insurance to cover services they will likely receive in the future and requires eligible beneficiaries to enroll promptly or pay a significant penalty. The Medicare Hospital Insurance program, created in 1965, collects payroll taxes from Americans throughout their working lives to pay for institutional care for individuals when they reach age sixty-five or become disabled, and imposes a serious penalty on individuals who decline enrollment, namely the loss of Social Security. This approach to ensuring that eventual beneficiaries contribute appropriately to the insurance pool in advance is more broadly applicable and imposes a higher cost on non-participation than the penalty under the ACA's minimum coverage provision.[2]

Finally, the history of the minimum coverage requirement itself has been sorely mischaracterized and misunderstood. Although the requirement has been widely criticized as part of a "government takeover" of the health care system or as a radical new idea, in fact it is an idea often promoted in the past by conservative political voices and comes from market-oriented approaches and proposals to achieve

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[2] Although the Medicare medical (Part B) and prescription drug (Part D) programs are voluntary programs, beneficiaries who decline enrollment forfeit a significant financial benefit, and those who delay enrollment without cause when they first become eligible face substantial penalties. *See infra* at 22.

widely supported goals of ensuring quality, affordable and broadly accessible health care. Congress enacted the minimum coverage requirement explicitly to preserve and improve the functioning of the nation's private health care system and thereby avoid creating a new direct federal program for funding health care. In fact, by utilizing several key mechanisms, including the minimum coverage provision, the ACA leaves the basic structure of the nation's health care system largely unchanged, preserving rather than radically altering that system.

ARGUMENT

I. CONGRESS HAS SUPPORTED AND REGULATED THE NATION'S HEALTH CARE DELIVERY AND FINANCE SYSTEM FOR DECADES.

The U.S. health care system is typically regarded as fundamentally private—distinct among industrialized nations in its reliance on the private rather than the public sector to provide and finance medical care. But an examination of the system's evolution, as well as its current operations, makes clear that public—and, more specifically, federal— support and direction has long been fundamental to the design and operation of the nation's "private" health care system. Alongside federal support for the private health care system has come federal regulation—initially focused primarily on assuring health and safety, but extended repeatedly to prevent discrimination in access to care, secure emergency care, limit the oversupply of health services through health planning, influence professionals' provision of services through payment incentives and protect the privacy of patients and consumers in the use of medical records.

In short, the U.S. private health care system is grounded in public policy that aims to assure access to safe, effective and affordable care. The ACA and its minimum coverage provision falls squarely within that tradition.

A. Federal Financing Has Provided The Underpinnings For Private Health Care Delivery And Insurance.

As described in detail below, throughout the country's history, Congress has enacted legislation that supplemented and encouraged the development of the nation's health care delivery system and the financing of it principally through and in reliance upon private insurance mechanisms.

1. Federal Support for Health Care Delivery

The nation's health care providers—institutional and professional—are overwhelmingly private. *See* KAISER FAMILY FOUNDATION, STATE HEALTH FACTS: UNITED STATES, HOSPITALS BY OWNERSHIP TYPE (2009), http://www.statehealthfacts.org/comparebar.jsp?ind=383&cat=8. But public investment underlies much of the evolution and the current operation of the private organizations that deliver care.

The availability of hospitals in sparsely as well as densely populated regions is a direct product of public, and often federal, investment. Federal support for care in rural areas began in the 1930s, when the federal Farm Security Administration helped finance rural health cooperatives that eventually covered 600,000 Americans. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE at 304. In 1946, Congress enacted the Hospital Construction and Survey Act ("Hill–Burton Act") to provide federal grants for hospital construction, which, over the next

two decades, assisted the financing of 9,200 new medical facilities and 416,000 new beds nationwide. Pub. L. No. 79-725, 60 Stat. 1040 (1946); *see* STUART ALTMAN & DAVID SHACTMAN, POWER, POLITICS, AND UNIVERSAL HEALTH CARE: THE INSIDE STORY OF A CENTURY-LONG BATTLE 114 (Prometheus Books 2011).

The Medicare and Medicaid programs, enacted in the mid-sixties, further drove hospital growth and development. These programs dramatically expanded the population of paying hospital patients. Their initial terms of payment (cost reimbursement, including a return on capital), were designed to reflect practices of private insurers and supported the expansion of hospital resources. JUDITH FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE 53-70 (Lexington Books 1977). Similarly, the nursing home industry emerged in the middle of the last century in response to access to federal funding, most significantly Medicaid. Subsequent refinement in Medicare hospital payment methods in 1983 (specifically, adoption of "per case" payments[3]) dramatically altered hospital practice—shortening hospital stays, and driving the development of both outpatient surgery and post-acute care facilities. RICK MAYES & ROBERT BERENSON, MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE 98-101 (The Johns Hopkins University Press 2006).

The size and nature of the nation's health workforce similarly reflects a combination of specifically

[3]Under "per case" payments, a hospital is paid a set price for each in-patient stay rather than a separate payment for each day a patient is in the hospital or for each service provided a patient.

targeted federal government policies and the impact of government insurance. Alongside enactment of Medicare and Medicaid, which increased the demand for physicians' services, Congress initiated support for training to assure the availability of physicians to meet that demand. Robert Field, *Government as the Crucible for Free Market Health Care: Regulation, Reimbursement, and Reform,* 159 PENN. L. REV. 1669, 1694-98 (2011). Government support allowed existing medical schools to expand and stimulated the creation of new ones, increasing the physician supply. Medicare contributed to this training effort by including in payments to hospitals amounts to support graduate medical education, i.e., the clinical training of new physicians who act as hospital staff. Medicare policy not only influenced the number but also the kind of physicians available by determining the number of training "slots" in each specialty its payments support. *Id.*

Medicare's physician payment policy has greatly influenced the way physicians practice medicine. Medicare's resource-based physician fee schedule, adopted in 1989, established the general standard by which physicians have subsequently been paid.[4] MAYES & BERENSON, MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE at 81-92. Professionals, like institutional providers, have adapted to Medicare's payment incentives, which overvalue technologically-oriented services at the expense of primary care. *Id.* at 146.

Government policy has also driven innovation in the treatments health professionals provide. The National Institutes of Health ("NIH"), created in its

[4] Under this fee system, doctors are paid a set fee for each service based on the resources needed to produce the service.

current form by legislation enacted shortly after World War II, has funded tens of thousands of researchers—in-house and around the nation—conducting the basic and clinical research that continually advances clinicians' understanding and treatment of disease. Field, 159 PENN L. REV. at 1669-706. The nation's pharmaceutical industry relies heavily on this research to support the development and dissemination of new products. *Id.*

The symbiotic relationship between publicly-funded research and privately-delivered products and treatment is nowhere more visible today than in the development of genomics from NIH's investment in mapping the human genome. *Id.* at 1705-06. The emerging ability to determine susceptibility to and potentially treatment of disease based on an individual's specific genetics offers a dramatic illustration of how publicly-supported basic research transforms privately-delivered medical and pharmaceutical treatment. *Id.*

2. Federal Support for Private Health Insurance

Private health insurance emerged in the mid-twentieth century as the nation's primary means of assuring financial protection against the cost of illness. Public policy supported the initial development, growth, and long-term viability of the private insurance enterprise.

During the Great Depression, providers developed non-profit insurance (Blue Cross by hospitals; Blue Shield by physicians) to secure badly needed revenues. TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 56-69 (Duke University Press Books 2007). State tax preferences enabled them to form

and to compete with for-profit or commercial insurers, who were encouraged by the success of the Blue Cross/Blue Shield plans to offer health coverage as well.

But insurers needed a market. Beginning in the 1940s, employers became the prime target for private insurers' marketing efforts. Employment-based insurance provided the mechanism to overcome the considerable risk of adverse selection (the fact that those people most likely to purchase insurance will be those most likely to need it), enabling the spreading of risk and making insurance both viable and profitable. *Id.* at 59-61.

Federal policies were key to employers' receptivity to purchasing insurance on employees' behalf. In 1949, the National Labor Relations Board ruled that employee benefits were included within the "terms of conditions of employment" subject to collective bargaining under the National Labor Relations Act. In response, unions began to seek health benefits from employers that they had been unable to obtain through legislation. *Id.* at 62-63. Most critical over the long term, the 1954 Internal Revenue Code, clarifying and codifying administrative action by the Treasury Department in 1943, excluded employer-paid health insurance premiums from employees' taxable income, thereby reducing its costs relative to direct purchase. *Id.* at 64. This tax benefit—or as it is now recognized, tax expenditure—not only entrenched private health insurance, but has become, at $246 billion for 2007, the federal government's third most expensive health care program. Paul N. Van de Water, *Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform*, CENTER ON BUDGET AND POLICY PRIORITIES,

June 4, 2009, http://www.cbpp.org/cms/index.cfm?fa=view&id=2832.

3. Public Absorption of Costly and Low Income Populations

Federally-supported health insurance dates almost back to the founding of the Republic. In 1798, Congress adopted an "Act for the Relief of Sick and Disabled Seamen," providing hospital care for merchant seamen funded through mandatory employer contributions. 1 Stat. 605 (1798), *available at* http://history.nih.gov/research/downloads/1StatL605.pdf. The federal government provided medical care for soldiers and sailors since the Revolutionary War and in 1921 created the Veteran's Hospital Program. ROSEMARY STEVENS, THE PUBLIC PRIVATE HEALTH CARE STATE: ESSAYS ON THE HISTORY OF AMERICAN HEALTH CARE POLICY 98 (Transaction Publishers 2007). In 1921, Congress also adopted the Sheppard-Towner Maternity and Infancy Protection Act to provide funding to states to provide health care for pregnant women, mothers and their children. 42 Stat. 224 (1921).

The modern era of public health insurance programs began in 1950, when federal funding for state payments to health care providers for medical care for the poor first became available. TIMOTHY STOLTZFUS JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 80 (Oxford University Press 2003). The Kerr-Mills Act of 1960 expanded this program, providing federal funds to the states to pay health care providers for serving low-income seniors. Congress soon replaced and eclipsed that program by enacting the far-broader Medicare and Medicaid programs in 1965—programs designed to complement and sustain, rather than replace, pri-

vate health insurance. THEODORE R. MARMOR, THE POLITICS OF MEDICARE 11-15 (2nd ed., Aldine Transaction 2000).

Medicare was explicitly aimed at the retired population, which was not being served by burgeoning employer-sponsored private health insurance. Medicare removed expectations and pressures on private insurers to include the elderly, averted the higher premiums their inclusion in the risk pool would have required, and thereby enhanced the viability of private employer-sponsored health insurance.

In addition, the enactment of Medicare created a market for private "Medigap" insurance. The elderly could not provide a viable market for private insurance, given the high cost of insuring this group and the absence of a natural grouping, like employment, to pool risk across healthy and less healthy individuals. But the existence of Medicare as the core provider of health insurance for older Americans made it possible for private insurers to market successfully "Medigap" insurance policies, now widely held by Medicare beneficiaries to fill the significant gaps in Medicare's coverage.

Medicaid, enacted alongside Medicare, similarly removed from private insurers' potential risk pool both people whose incomes would make their payment of premiums unreliable and many people whose health risks would, if included, significantly drive up premium costs and undermine coverage. Medicaid's coverage of low-income and disabled people needing treatment, not only for acute care but for serious mental illness, serious substance abuse, costly HIV/AIDS drugs, and long-term care services, enabled private insurers to focus on a largely

healthy population and offer a more manageable, less costly package of benefits.

CHIP, which Congress enacted in 1997 to insure children in families with modest incomes that were too high to qualify for Medicaid was explicitly designed to preserve private insurance. The program requires states to adopt strategies to keep CHIP coverage from replacing or "crowding-out" private health insurance. 42 U.S.C. § 1397bb(b)(3)(C).

All three programs—Medicare, Medicaid, and CHIP—rely on private health insurers for program operations. From the outset, Medicare has relied on private health insurers for program administration, contracting initially with Blue Cross and Blue Shield plans to manage claims. FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE at 37. Medicare also supports participation of private health plans ("Medicare Advantage" plans) from which a quarter of the beneficiary population currently gets both core Medicare and supplementary benefits. MEDICARE PAYMENT ADVISORY COMM'N, MEDICARE PAYMENT POLICY 290-91 (2011), *available at* http://www.medpac.gov/documents/Mar03_Entire_report.pdf. For prescription drug coverage (enacted in 2003), Medicare relies exclusively on—and heavily subsidizes—private health insurance plans. *Id.* at 319-20. CHIP, from its inception, has relied on private health plans to provide benefits. Over the course of the last two decades, Medicaid has moved largely to reliance on private managed care plans to cover children and non-disabled adults who constitute the bulk of the program's enrollees. KATHLEEN GIFFORD ET AL., A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY 2 (The Henry J. Kaiser Family Foundation

2011), *available at* http://www.kff.org/medicaid/upload/8220.pdf.

B. Federal Regulation Has Also Shaped The Nation's Health Care System.

Federal regulation both predates and extends the influence of federal financing in shaping the American health care system.

1. Federal Regulation of Drugs and Institutional and Physician Care

The earliest federal regulation focused on biologics (1902) and drugs (1906). Peter Barton Hutt, *The Transformation of American Food and Drug Law*, 60 J. ASS'N FOOD & DRUG OFFICIALS 9, 16-19 (1996); *see also* DANIEL CARPENTER, REPUTATION AND POWER: ORGANIZATIONAL IMAGE AND PHARMACEUTICAL REGULATION AT THE FDA 75 (Princeton University Press 2010). Since 1938, it has been illegal, under the Federal Food, Drug, and Cosmetic Act, to market a drug in the United States without the federal government's permission. CARPENTER, REPUTATION AND POWER at 73-117. The federal government has both funded the basic research that has made modern pharmaceuticals possible and regulated new drugs, biologics and devices to ensure that they are in fact safe and effective.

With federal dollars came more federal requirements to guide their use. When the 1946 Hill–Burton Act provided funding to build hospitals, it also required them to fill specific community service obligations and to provide some services for free or reduced cost for those unable to afford health care. ALTMAN & SHACTMAN, POWER, POLITICS, AND UNIVERSAL HEALTH CARE at 112-21. Similar requirements were initially imposed on hospitals as a condition for designation as "charitable institutions," a

designation that, under a 1956 Revenue Ruling, exempts the institution from federal taxes. *See* Daniel Fox & Daniel Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. Health Pol., Pol'y & L. 251, 257 (1991).

The 1974 National Health Planning and Resources Development Act ("NHPRDA") imposed extensive federal controls over health care institutions throughout the United States, creating regional and local health planning agencies and requiring new and expanding facilities to obtain a "certificate of need" before beginning construction. Pub. L. No. 93-641, 88 Stat. 2225 (1975); *see* ALTMAN & SHACTMAN, POWER, POLITICS, AND UNIVERSAL HEALTH CARE at 211-12. The NHPRDA, which expired in 1986, established a far-reaching precedent for federal regulation of institutional health care. *See generally North Carolina ex rel. Morrow v. Califano*, 445 F. Supp. 532 (D.N.C. 1977) (upholding the constitutionality of the NHPRDA).

Most relevant to the matter before the Court, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, adopted as part of the Consolidated Omnibus Reconciliation Act of 1985, requires that, if a hospital participates in Medicare and has an emergency department, it must screen and stabilize individuals who come to the hospital in an emergency (or in active labor). BARRY FURROW ET AL., HEALTH LAW 609-23 (6th ed., West 2008). Congress passed this statute in response to widespread reports of private hospitals transferring unstablized patients to public hospitals because they were uninsured. *Id.* at 609-11.

EMTALA has been a major factor in securing access to medical treatment for many uninsured per-

sons. However, it has increased the uncompensated care burden of hospitals and shifted involuntarily the cost of uncompensated care to the purchasers of private insurance. This cost-shifting is one of the market failures that the ACA attempts to address by seeking to have everyone obtain their own insurance.

Congress has not only regulated institutional care, but also directly regulated the practice of medicine. The Controlled Substances Act, adopted in 1970, regulates physician practice by requiring doctors to be registered with the Drug Enforcement Administration in order to be able to prescribe certain drugs and by prohibiting doctors from prescribing other drugs at all. 21 U.S.C. §§ 811–831; *see Gonzales v. Raich*, 545 U.S. 1 (2005) (upholding constitutionality under commerce clause). The Health Insurance Portability and Accountability Act of 1996 authorized detailed regulations governing the security and confidentiality of patient records, which apply to health care professionals as well as institutions. 42 U.S.C. §§ 1320d–1320d-9. Finally, this Court recently upheld a federal law prohibiting medical professionals from carrying out a particular abortion procedure, affirming the power of Congress "exercised in this instance under the Commerce Clause, to regulate the medical profession." *Gonzales v. Carhart*, 550 U.S. 124, 166 (2007).

2. Federal Regulation of Private Health Insurance

The federal government has also long and extensively regulated private health insurance. The Supreme Court recognized the authority of Congress to regulate insurance in 1944. *See United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944). Although Congress recognized the continuing authority of the states to regulate insurance in

the McCarran-Ferguson Act, it only preserved state regulation to the extent that it was not preempted by federal law. 15 U.S.C. § 1012. The Health Maintenance Organization ("HMO") Act of 1973 provided federal assistance for HMOs that met certain regulatory requirements and imposed a mandate that every employer with more than twenty-five employees that offered health insurance offer an HMO option if one were available. 42 U.S.C. §§ 300e–300e-17; *see* ALTMAN & SHACTMAN, POWER, POLITICS, AND UNIVERSAL HEALTH CARE at 35-42.

The 1974 Employee Retirement Income Security Act ("ERISA") expanded federal regulatory authority much further, assuming regulatory oversight for employer-sponsored health insurance covering 85 percent of privately-insured Americans. Pub. L. No. 93-406, 88 Stat. 829 (1974). This Court has interpreted ERISA to preempt completely all state regulation of self-insured plans. *See FMC Corp. v. Holliday*, 498 U.S. 52, 60-61 (1990). Although ERISA permits the states to continue to regulate health insurers, it requires ERISA plan members to seek relief in federal court under federal law if they are denied benefits. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

HIPAA, mentioned above, expanded federal authority over health insurance even further, imposing many requirements elaborated under the ACA. HIPAA prohibits health status underwriting within group insurance plans and requires guaranteed issue and renewal for insured small group plans. 29 U.S.C. § 1182; 42 U.S.C. §§ 300gg-1, 300gg-2. It also defines and limits the use of pre-existing condition exclusions for group plans. 29 U.S.C. § 1181(a). It extended federal authority to individual plans as well, imposing guaranteed issue and renewal re-

quirements and banning pre-existing conditions clauses under some circumstances. 42 U.S.C. §§ 300gg-41, 300gg-42. Indeed, the insurance reform requirements of Title I of the ACA are simply amendments to HIPAA that extend its protections.

Congress has adopted a host of other laws addressing specific health insurance issues. The 1990 Americans with Disabilities Act prohibits employers and insurers from discriminating against persons with disabilities. 42 U.S.C. §§ 12101-12117. Another 1990 law standardizes private Medigap insurance, limiting the types of policies that can be sold to Medicare beneficiaries. 42 U.S.C. § 1395ss.

Federal laws adopted in the 1990s and 2000s impose specific requirements on insurers regarding maternity coverage, breast reconstruction following mastectomy and mental health coverage, and prohibiting discrimination based on genetics. 29 U.S.C. §§ 1185–1185c, 42 U.S.C. §§ 300gg-1, 300gg-53. Finally, the 2003 Medicare Modernization Act provides federal tax subsidies for Health Savings Accounts, but only if they are accompanied by high-deductible health insurance plans that meet very specific statutory requirements. 26 U.S.C. § 223.

* * *

In sum, as Judge Marcus correctly observed in dissent below:

> It would surely come as a great shock...to the 47.5 million people covered by Medicare, the 44.8 million people covered by Medicaid, and the overwhelming number of employers, health insurers, and health care providers regulated by ERISA, COBRA, and HIPPA, to learn that, because the

> health care industry also 'falls within the sphere of traditional state regulation,' [quoting the Eleventh Circuit majority opinion], Congress was somehow skating on thin constitutional ice when it enacted these laws.

Florida, 648 F.3d at 1345 (Marcus, J., dissenting in part). Title I of the ACA is not an "encroachment on...areas of traditional state concern." It is rather part of a long-standing practice of pervasive federal regulation of health care delivery and finance in the United States.

II. THE MINIMUM COVERAGE PROVISION IS NOT UNPRECEDENTED, BUT IS CONSISTENT WITH ESTABLISHED FEDERAL LAW.

As is explained below, the minimum coverage requirement is not unprecedented, but is consistent with the past and proper scheme of federal regulation of health care, and is, indeed, a "necessary and proper" part of that larger scheme of federal regulation.

A. Congress Has For Decades Through Medicare Mandated And Imposed Penalties For Failure To Make Provision For Likely Future Medical Needs.

The Eleventh Circuit was fundamentally mistaken when it faulted the minimum coverage provision as "overinclusive" because "it conflates those who presently consume health care with those who will not consume health care for many years into the future." *Florida*, 648 F.3d at 1295. The essence of insurance is the pooling of people who are currently using health care with those who will not use it for many years, if ever. Without such pooling, the price

of insurance would be the price of care for those who are using it now. Current and future users must be pooled to make insurance affordable.

Congress has since 1965 required Americans to pay a payroll tax, currently equal to 2.90 percent of income, into the Medicare Hospital Insurance Trust Fund, so that they will be eligible for Medicare when they "consume health care…many years in the future." *Id.* To be fully eligible for Medicare Part A, an individual (or spouse) must generally pay payroll taxes for ten years. 42 U.S.C. §§ 402, 414, 426. Further, substantial penalties are imposed on individuals who decline or delay Medicare coverage once they are eligible for it, even though they have no current health care needs. An individual who declines Medicare Part A coverage forfeits Social Security coverage as well. *See Hall v. Sebelius*, 770 F. Supp. 2d 61, 66-68 (D.D.C. 2011).

Enrollment in other parts of Medicare is "voluntary," but they also carry substantial costs for nonparticipation. If an individual fails to enroll in Medicare when first eligible without good cause (for example, because of continuing employer-sponsored coverage), a 10 percent surcharge is added to the normal Part B premium for the rest of the individual's life for each twelve months that enrollment is delayed. 42 U.S.C. § 1395r(b). Similarly, delay in applying for coverage for Part D drug coverage results in a 1 percent penalty increase in the premium per month unless an exception applies. 42 U.S.C. § 1395w-113(b).

The fact that these powerful incentives and absolute requirements are pervasive and established tools of federal health sector policy belies the Eleventh Circuit's claim that the ACA minimum coverage provision is "unprecedented" as an interference

with individual choice, and, hence, should be held to breach a hereto unknown limitation on Congress' power under the Commerce Clause.

Moreover, as Judge Kavanaugh observed in his D.C. Circuit opinion:

> Privatized social services combined with mandatory-purchase requirements of the kind employed in the individual mandate provision...might become a blueprint used by the Federal Government over the next generation to partially privatize the social safety net and government assistance programs….

Seven Sky, 661 F.3d. at 53 (Kavanaugh, J., dissenting).

Congress should not be barred from utilizing an approach to remedying deficiencies in access to health insurance and services that is actually less coercive than approaches Congress has lawfully utilized under its Tax and Spend authority in the past to achieve the same goal.[5]

B. Congress Properly Addressed The Problem Of Cost-Shifting Prospectively Rather Than At The Point Of Consumption.

The Eleventh Circuit acknowledged that Congress could, under the Commerce Clause, directly regulate the behavior of the uninsured at the point

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[5] In his Sixth Circuit opinion, Judge Sutton also observed that Congress adopted the minimum coverage requirement as an alternative to using its Tax and Spend authority to reach the same goal. *Thomas More Law Ctr.*, 651 F.3d at 550, 552-53 (Sutton, J., concurring in part and delivering the opinion of the Court in part).

they actually consume care. *Florida*, 648 F.3d at 1294-95. But Congress has, for decades, explicitly rejected that approach. Indeed, the 1986 Emergency Medical Treatment and Active Labor Act is based on the reasonable judgment of Congress that the point in time when a patient shows up at a hospital in an emergency is the wrong time to impose a payment mandate. By imposing instead a mandate on the hospital to provide urgently-needed medical services, EMTALA has, however, contributed to the growing uncompensated care burden on health care providers and effectively forced them to shift much of the burden of uncompensated care to public and private insurance programs.

The federal government indisputably has the responsibility to protect taxpayers and beneficiaries from costs shifted to Medicare and Medicaid attributable to the uninsured. *Id.* But it also has the responsibility to protect employees insured through employer-sponsored insurance—the vast majority of privately insured Americans—from provider cost-shifting. First, a significant share of the cost of these plans is passed on to the federal government through tax expenditures, as noted above. Furthermore, ERISA imposes fiduciary duties on the administrators of employee plans. To the extent that cost-shifting increases the cost of these plans, ERISA fiduciaries are spending money that is not going to the sole benefit of plan participants and beneficiaries. 29 U.S.C. § 1104(a)(1)(A).

While EMTALA reflects the consensus that it is morally wrong to deny care to people in extremis, the minimum coverage requirement recognizes that it is also wrong to allow people to shift the cost of their care to others by refusing to provide responsibly for their future health care needs. In that regard, the

minimum coverage requirement is not a radical departure from the past, as the Eleventh Circuit concluded. Rather, it is a reasonable component of a larger, long-standing federal effort to encourage Americans to pay for their health care needs by protecting those who do act responsibly from the costs imposed by those who fail to do so.

III. THE MINIMUM COVERAGE PROVISION ORIGINATED AS A MARKET-FACILITATING SOLUTION TO THE PROBLEM OF PRESERVING PRIVATE INSURANCE.

All health insurance programs face the problem of adverse selection, which raises premiums and drives healthy individuals away, thus destabilizing insurance pools. The problem is especially acute if, as here, insurance regulation enhances sicker individuals' access to coverage by requiring insurers to take all comers and barring insurers from charging higher premiums to persons with pre-existing conditions.

One solution to this problem is to require all individuals to participate in an insurance pool and contribute to its financing. Social insurance programs like Medicare require that all working-age Americans contribute payroll taxes that establish their eligibility for future benefits, as described above. Proposals to create a national health insurance system in the United States, like the 1943 Wagner-Murray-Dingell and 1974 Kennedy-Mills bills, followed the social insurance model, proposing that all U.S. residents be required to make payroll tax contributions to fund a federal health insurance program. JACOB HACKER, THE DIVIDED WELFARE STATE: THE BATTLE OVER THE PUBLIC AND PRIVATE SOCIAL BENEFITS IN THE UNITED STATES 224, 254 (Cam-

bridge University Press 2002). But if payroll tax financing is not used, government health insurance programs require functionally equivalent mechanisms to assure broad participation and avoid adverse selection.

Health reform proposals since the 1970s in fact have increasingly moved away from the model of a single government health plan and instead have sought to build on the existing public-private health insurance structure. These proposals to move towards universal health insurance while relying on private insurance have long embraced the idea of requiring individuals to obtain insurance. The minimum coverage requirement is intended to make private insurance work by mitigating the adverse selection problem and facilitating the enrollment of healthy persons into broad risk pools. Like Medicare's payroll tax, the coverage requirement ensures that individuals will contribute to the costs of their medical care before they require assistance, addressing the cost-shifting problem through collective financing and prepayment.

The roots of the minimum coverage requirement lie in proposals for universal health insurance offered by politically conservative scholars and organizations which included a requirement called an "individual mandate." In 1989, Stuart Butler authored a health reform proposal for the Heritage Foundation that called for a mandate to purchase private coverage (along with tax credits to make purchasing coverage affordable). The Heritage plan explicitly described the individual mandate as an alternative both to national health systems abroad and to U.S. health reform proposals that would mandate employers to finance coverage for their workers. *See* Stuart Butler, *Assuring Affordable Health Care for*

All Americans, 218 THE HERITAGE LECTURES 1, 2, 3, 6 (1989), *available at* http://thf_media.s3.amazonaws.com/1989/pdf/hl218.pdf.

According to Butler, the health insurance requirement is built on the principle of individual responsibility and an implicit contract under which society feels an obligation to assist sick persons requiring medical care regardless of whether they have health insurance, even if that means the rest of us "end up paying the tab" for their care. *Id.* at 6. Butler concluded that

> [a] mandate on individuals recognizes this implicit contract. Society does feel a moral obligation to insure that its citizens do not suffer from the unavailability of health care. But on the other hand, each household has the obligation, to the extent it is able, to avoid placing demands on society by protecting itself.

Id.

In 1991 health economist Mark Pauly and colleagues developed a similar health reform plan for the administration of President George H.W. Bush. Their plan for "responsible national health insurance" required "all citizens to obtain a basic level of health insurance," Mark V. Pauly et al., *A Plan for "Responsible National Health Insurance"*, 10 HEALTH AFF. 5, 8 (Feb. 1991), while providing tax credits to help make insurance purchase affordable for Americans with lower incomes. The plan was envisioned as an alternative to national health plans funded by general revenues, such as the British National Health Service. Noting that lack of insurance "may impose costs on others, because we as a society pro-

vide care to the uninsured," Pauly argued that "the risk of shifting costs to others has led many states to mandate that all drivers have liability insurance. The same logic applies to health insurance." *Id.*

During the 1993-94 health reform debate, the individual mandate model attracted significant Republican support. In 1993, the Senate Republican Health Care Task Force issued "consensus principles on health care reform." Twenty-four Republican Senators signed the statement of principles, which included "individual responsibility." The Senators wrote that "we believe individuals must assume responsibility for securing their own insurance. As long as there are adequate subsidies to make health insurance affordable for the poor and the unemployed, everyone must take responsibility for preparing for an unexpected health crisis." ROBERT F. BENNETT ET AL., SENATE REPUBLICAN TASK FORCE CONSENSUS PRINCIPLES FOR HEALTH CARE REFORM 6 (1993), *available at* http://legacy.library.ucsf.edu/tid/rzf48d00/pdf.

The same year, Senator John Chafee of Rhode Island, leader of the Republican health care task force, proposed legislation that required individuals to obtain health insurance. The Chafee bill had 19 Republican and two Democratic cosponsors. *See Summary of a 1993 Republican Health Reform Plan*, KAISER HEALTH NEWS, Feb. 23, 2010, http://www.kaiserhealthnews.org/Stories/2010/February/23/GOP-1993-health-reform-bill.aspx. Another 1993 Republican health bill, sponsored by Senator Don Nickles of Oklahoma and Representative Cliff Stearns of Florida, required individuals to purchase private health insurance; if they failed to do so, they would be enrolled automatically in a state-sponsored government health program. Tom Miller, *Cato Insti-*

tute Policy Analysis No. 210: Nickles-Sterns is Not the Market Choice For Health Care Reform, POLICY ANALYSIS, June 13, 1994, http://www.cato.org/pubs/pas/pa210.pdf, at 2.

Many Republicans embraced the coverage requirement as an alternative to President Clinton's proposed 1993 Health Security Act ("HSA") employer mandate. Yet the HSA also proposed requiring Americans to make payments towards the purchase of private health insurance. CONG. BUDGET OFFICE, AN ANALYSIS OF THE ADMINISTRATION'S HEALTH CARE PROPOSAL 9-11 (1994), http://www.cbo.gov/ftpdocs/48xx/doc4882/doc07.pdf.

In the past decade, an individual mandate or coverage requirement has been a regular feature of health care reform plans that seek to build on private insurance to move towards universal coverage. The requirement has attracted support from a wide range of analysts and politicians, including former Speaker of the House Newt Gingrich, who in 2007 argued that Congress should "require anyone who earns more than $50,000 a year to purchase health insurance or post a bond." Newt Gingrich, *Covering the Uninsured—Do We Want Markets or Mandates?*, CENTER FOR HEALTH TRANSFORMATION, June 25, 2007, http://www.healthtransformation.net/cs/opeds_news?pressrelease.id=33. In 2009, former Senate Majority leader Bill Frist endorsed an individual mandate for "a minimum level of health coverage," noting that a mandate "is the only way to achieve affordable health insurance coverage for every American in a pluralistic, public-private sector." William H. Frist, *Frist: An Individual Mandate for Health Insurance Would Benefit All*, U.S. NEWS & WORLD REPORT, Sept. 28, 2009, *available at* http://www.usnews.com/opinion/articles/2009/09/28/

frist-an-individual-mandate-for-health-insurance-would-benefit-all.

Most prominently, in 2006, Massachusetts enacted a health reform law that, along with expanding Medicaid and providing subsidies to help lower-income persons afford coverage, required state residents to obtain insurance or pay a tax penalty. The Massachusetts law was backed by Republican Governor Mitt Romney and enjoyed broad bipartisan support in the state legislature, passing the state House 155-2 and the Senate 37-0. John E. McDonough et al., *The Third Wave of Massachusetts Health Care Reform*, 25 HEALTH AFF. w420, w430 (Nov. 2006). Governor Romney defended Massachusetts' decision to impose penalties on people who did not purchase insurance as a "personal responsibility principle," stating that "someone has to pay for the health care that must, by law, be provided: either the individual pays or the taxpayers pay." Mitt Romney, *Health Care for Everyone? We've Found a Way,* WALL ST. J., April 11, 2006, at A16.

The ACA emulated Massachusetts by requiring that Americans either obtain insurance or pay a penalty. Notably, alternatives to the ACA that also rely on private insurance, including those supported by Republicans, have proposed similar requirements to ensure broad participation in insurance pools. For example, the Healthy Americans Act, first introduced in 2007 and sponsored by Senators Ron Wyden, Democrat of Oregon and Robert Bennett, Republican of Utah, would have required all Americans to obtain insurance coverage. It drew seventeen cosponsors, including nine Republicans. S. 334, 110th Cong. (2007).

A 2009 health care reform bill (the "Patients' Choice Act") cosponsored by Republican Senators

Richard Burr of North Carolina and Tom Coburn of Oklahoma and Republican Congressmen Paul Ryan of Wisconsin and Devin Nunes of California proposed "facilitating universal coverage" by automatically enrolling Americans into state health insurance exchanges at government offices, including "State departments of motor vehicles" and through "the submission of State tax forms." H.R. 2520, 111th Cong. § 202(c)(1) (2009). In addition, under the Patients' Choice Act, a "state exchange shall include an incentive for eligible individuals to remain insured from plan year to plan year, and may include incentives such as State tax incentives or premium-based incentives." *Id.* at § 202(c)(2)(C).

Further, the Roadmap for America's Future Act of 2010 introduced by Republican Congressman Ryan called for eliminating the current tax exclusion for employer contributions to workers' health insurance premiums and replacing it with refundable tax credits to purchase private insurance, so that people who choose not to have health insurance would have higher tax bills than those who purchase coverage. H.R. 4529, 111th Cong. §§ 112, 133 (2010). This provision, like the ACA's minimum coverage requirement, sought to create economic incentives for individuals to purchase private insurance. Simon Lazarus, *Paul Ryan's "Individual Mandate"*, SLATE, May 3, 2011, http://www.slate.com/articles/news_and_politics/jurisprudence/2011/05/paul_ryans_individual_mandate.html.

Finally, recent Republican plans to reform Medicare also have adopted financial incentives and policies to compel beneficiaries to purchase private insurance. Under the 2012 budget resolution passed by the Republican majority in the House of Representatives, the traditional government-operated

Medicare program would have been eliminated and beneficiaries would instead have received subsidies to purchase private insurance. All Medicare beneficiaries would have been forced to carry private insurance. Yet the Medicare hospitalization insurance payroll tax would have remained mandatory, and Medicare's premium penalties for late enrollment in Part B and Part D would have remained in place, so that the federal government would have consequently "compel[ed] people to pay for private health insurance policies." *Id.*

In sum, the minimum coverage requirement has a long history of wide bipartisan support. The requirement has attracted support from conservative policy analysts and Republican politicians because of its emphasis on individual responsibility and its potential to remedy the "free rider" or cost-shifting problem. Indeed, ten current Republican Senators who now oppose the minimum coverage requirement as unconstitutional previously sponsored or co-sponsored legislation that included an individual mandate.[6] In addition, the coverage requirement is widely recognized as an integral element to health reform plans that seek to build on private insurance and stabilize private insurance pools.

The importance of financial incentives to ensure broad participation and risk pooling in private insurance is confirmed by the fact that alternatives to

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[6] These Senators are: Sen. Lamar Alexander (R–Tenn.), Sen. Daniel Coates (R–Ind.), Sen. Bob Corker (R–Tenn.), Sen. Mike Crapo (R–Idaho), Sen. Lindsey Graham (R-S.C), Sen. Chuck Grassley (R–Iowa), Sen. Orin Hatch (R–Utah), Sen. Kay Bailey Hutchison (R–Tex.), Sen. Richard G. Lugar (R–Ind.) and Sen. John McCain (R–Ariz.). *See* S. 1743, 103rd Cong. (1993); S. 1770, 103rd Cong. (1993); S. 1807, 103rd Cong. (1994); S. 334, 110th Cong. (2007); S. 391, 111th Cong. (2009).

the ACA proposed by conservative politicians and policy analysts also contain financial incentives to induce purchase of private insurance. Although some of the individuals and organizations that have historically supported the minimum requirement have more recently disavowed their support as the requirement has become politically unpopular in certain quarters, the history of broad support for coverage requirements ultimately reflects a desire to build a universal health insurance system that retains private insurance, rather than turning to the alternative of tax-financed and government-operated national health insurance. The requirement is a critical piece to making private insurance work in a reformed health care system.

IV. THE AFFORDABLE CARE ACT WILL PRESERVE THE PUBLIC/PRIVATE STRUCTURE OF OUR HEALTH CARE SYSTEM.

Although Congress enacted the ACA to address major problems that plague the nation's health care system, it will not, in the end, produce radical changes in the current private-public health care financing and delivery system.

As described above, during the past century, America has developed a mixed health care system with prominent roles for both the public and private sectors. Three major sources of health care financing—employer-sponsored coverage, Medicare and Medicaid—presently cover the vast majority of Americans. Medicare and Medicaid are, of course, programs that Congress created. Employer-sponsored coverage has emerged in response to and been shaped by congressional initiatives. Fifty million U.S. residents, however, continue to lack any health insurance. U.S. CENSUS BUREAU, INCOME,

POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23.

The ACA incorporates several strategies to preserve the nation's mixed private-public health insurance system, while extending coverage to the uninsured. Specifically the ACA:

- creates state-level health insurance exchanges to improve access to health insurance for individuals and small businesses and encourage competition among insurance plans, Pub. L. No. 111-148, §§ 1311, 1321, 124 Stat. 173, 186 (2010);
- offers premium tax credits and cost-sharing subsidies to lower- and middle-income uninsured Americans, *id.* at §§ 1401, 1402, 124 Stat. at 213, 220;
- prohibits risk selection and medical underwriting by insurers against persons with pre-existing conditions, *id.* at § 1201, 124 Stat. at 154;
- expands Medicaid eligibility to cover all Americans with incomes lower than 133 percent of the Federal Poverty Level, *id.* at § 2001, 124 Stat. at 271;
- encourages employer-sponsored coverage by penalizing large employers whose employees are not covered by employer-sponsored insurance and who receive premium tax credits, *id.* at § 1513, 124 Stat. at 213; and
- requires households that can afford health insurance to purchase minimum coverage or pay a penalty, *id.* at § 1501, 124 Stat. at 242.

Combined, these strategies will substantially reduce the number of uninsured Americans. Insurance coverage among the nonelderly population will rise to an estimated 92 percent from 81 percent today, with 34 million Americans gaining coverage. CONG. BUDGET OFFICE, CBO'S MARCH 2011 ESTIMATE OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS CONTAINED IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2011), *available at* http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf.

But the ACA's impact on sources of health insurance and the structure of U.S. medical care will, in fact, be modest. Most Americans will continue to receive health insurance from the same sources that provide them with coverage today. According to the Congressional Budget Office ("CBO"), once the ACA is fully implemented in 2019, 163 million Americans will have employer-sponsored insurance, virtually unchanged from under prior law. Employer-sponsored private coverage will remain the predominant form of insurance for working-age Americans. *Id.* The CBO additionally estimates that 28 million Americans will obtain non-group coverage and that 24 million Americans will enroll in the new insurance exchanges. *Id.*

Medicare enrollment will be unchanged from prior law. Medicaid and CHIP enrollment will increase by 16 million, but these programs will continue to cover only the poorest Americans. Moreover, as most Medicaid programs contract with private managed-care plans to arrange enrollees' medical care, the Medicaid expansions will in fact expand services provided through private plans.

The ACA retains the existing foundations of American health insurance. The one new mecha-

nism it creates—the state health insurance exchanges—is designed to strengthen the market for private non-group coverage. Medical care delivery will remain largely in private hands under the ACA, as it is today.

CONCLUSION

The ACA does not create a new health care system, and it clearly does not constitute a federal government "takeover" of American health care. Rather it continues a policy towards health care that began in the middle of the last century through which Congress has continuously fostered the development of the nation's private health care delivery and financing system, filling gaps with public programs only as necessary. Previous market-based proposals to expand access to health insurance while maintaining private coverage have contained policy tools similar to those utilized by the ACA, including the minimum coverage requirement. The minimum coverage requirement also mirrors and builds on prior federal initiatives to structure health care financing by having Americans prepare responsibly for future health care needs by paying for coverage—public and private—in advance. The ACA will expand access to insurance coverage and to health care, but it will do so by reinforcing existing institutions and by preserving private insurance.

Thus, the minimum coverage requirement is not a "wholly novel" federal intervention in an area of "traditional state concern," but rather another chapter in the long history of attempts by Congress to preserve private insurance markets and ensure all Americans access to health care.

This Court should reverse the decision of the court below, and uphold the constitutionality of the minimum coverage provisions of the ACA.

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