No. 11-398

In the Supreme Court of the 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 ON BEHALF OF SINGLE PAYER ACTION, IT'S OUR ECONOMY, AND FIFTY MEDICAL DOCTORS WHO SUPPORT SINGLE PAYER AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (MINIMUM COVERAGE PROVISION)

Oliver B. Hall
Counsel of Record
1835 16TH STREET NW #5
WASHINGTON, DC 20009
(617) 953-0161
oliverbhall@gmail.com

Counsel for Amici Curiae

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Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

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INTEREST OF AMICI[1]

Amici are a coalition of non-profit organizations and medical doctors who are active in the effort to achieve universal and comprehensive healthcare access in the United States. *Amici* agree with Petitioners ("the Government") that the United States faces a healthcare crisis: the costs generated by the current healthcare system are unsustainable and continue to rise, yet nearly 50 million Americans risk denial of essential healthcare services because they lack insurance. *Amici* disagree, however, that this crisis can be solved by forcing uninsured Americans to purchase health insurance from private insurance companies, or pay a penalty, as the provision of the Patient Protection and Affordable Care Act ("ACA" or "the Act") commonly known as the "individual mandate" requires them to do. 26 U.S.C.A. 5000A. Instead, *Amici* believe, based upon sound empirical data and peer-reviewed research, that the only solution to the healthcare crisis in the United States, which will both control costs and achieve comprehensive coverage for the entire population, is to adopt a national publicly-financed single payer health insurance system, in which one public entity handles billing and other administrative transactions on behalf of all participants.

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *Amici* certifies that counsel authored this brief in its entirety. No attorney for a party authored any part of the brief, and no person or entity other than *Amici* made any monetary contribution to its preparation or submission. Counsel for both the petitioners and the respondents have given blanket consent to the filing of amicus briefs.

Congress has already implemented successful single payer systems that provide universal coverage to certain subsets of the population, including Medicare for citizens aged 65 and older, and the Veterans Health Administration ("VHA") for those who have served in the military. Yet Congress never seriously considered whether such a system could achieve the Act's goals of controlling healthcare costs and increasing coverage nationwide. For example, healthcare experts who support adoption of a national single payer system were not permitted to testify or provide evidence in hearings before the Senate Finance Committee, which drafted the legislation that became the ACA. Consequently, the findings on which the Act relies do not reflect the best available evidence regarding potential solutions to the United States' healthcare crisis. Likewise, in defending the constitutionality of the individual mandate, the Government characterizes the provision as necessary to the effective regulation by Congress of the national healthcare market, but disregards the proven success of single payer systems currently operating in the United States.

Amici thus submit this brief for the purpose of disputing the primary tenet of the Government's position, that Congress cannot regulate the national healthcare market effectively unless it has power to require that citizens purchase insurance from private insurance companies. On the contrary, as set forth herein, Congress has already demonstrated that it can regulate healthcare markets effectively by implementing a single payer system such as Medicare or the VHA. In fact, comparative data from other nations suggest that the administrative cost-savings attainable by adopting a national single payer system

in the United States would be sufficient to guarantee comprehensive and universal coverage to the entire population, without an increase in overall healthcare spending.

The evidence set forth herein also suggests that the Act's reliance on the individual mandate will exacerbate the very problems it intends to solve – out-of-control costs and the denial of essential healthcare services to millions of Americans – which result in untold suffering and tens of thousands of preventable deaths each year. As longtime advocates for meaningful healthcare reform, and in the case of most medical doctor *Amici*, as providers of healthcare services to the public within the healthcare system as it is currently organized, *Amici* have a strong interest in providing the Court with such evidence. Therefore, they submit this brief in support of Respondents State of Florida, et al. (the "States") and in opposition to the constitutionality of the individual mandate.

Single Payer Action is a project of The Daily Citizen, Inc., a 501(c)(4) non-profit corporation. Single Payer Action has a single mission: to achieve a single payer healthcare system in the United States, which guarantees healthcare coverage for all. Single Payer Action engages in advocacy, public education and other outreach efforts to promote its goals. Its website is www.singlepayeraction.org.

It's Our Economy is a non-profit operating as a 501(c)(3) organization that seeks to democratize the economy by shifting power from corporations to the American people. It advocates for a national publicly-financed single payer system that guarantees coverage to everyone in the United States, because people gain

greater control over their healthcare when health insurance companies are removed from in-between doctors and patients. Its website is www.ItsOurEconomy.US.

Fifty Medical Doctors Who Support Single Payer: Henry L. Abrons, MD, Berkeley, California; Patch Adams, MD, Urbana, Illinois; Kris Alman, MD, Portland, Oregon; James Binder, MD, Huntington, West Virginia; Barbara Blaylock, MD, Rockville, Maryland; Claudia Chaufan, MD, San Francisco, California; Allen R. Chauvenet, MD, Charleston, West Virginia; Brad Cotton, MD, Circleville, Ohio; Richard A. Damon, MD, Bozeman, Montana; Mary L. De Luca, MD, Albuquerque, New Mexico; Jess G. Fiedorowicz, MD, Iowa City, Iowa; Margaret Flowers, MD, Baltimore, Maryland; Elizabeth Frost, MD, Minneapolis, Minnesota; Leslie Hartley Gise, MD, Kula, Hawaii; James S. Goodman, MD, Albuquerque, New Mexico; Jeoffry Gordon, MD, San Diego, California; Matthew Hahn, MD, Berkeley Springs, West Virginia; Hedda L. Haning, MD, Charleston, West Virginia; Paul Hochfeld, MD, Corvallis, Oregon; Michael Huntington, MD, Corvallis, Oregon; Joseph Q. Jarvis, MD, Salt Lake City, Utah; Timothy Jordan, MD, Phoenix, Arizona; James G. Kahn, MD, San Francisco, California; Jeffrey Kaplan, MD, Baltimore, Maryland; Stephen B. Kemble, MD, Honolulu, Hawaii; Ronald Lapp, MD, Paso Robles, California; David McLanahan, MD, Seattle, Washington; Samuel Metz, MD, Portland, Oregon; Eric Naumburg, MD, Columbia, Maryland; Clark Newhall, MD, Salt Lake City, Utah; Carol Paris, MD, Leonardtown, Maryland; George L. Pauk, MD, Phoenix, Arizona; Julie Keller Pease, MD, Brunswick, Maine; Robert W. Putsch, MD, Canyon Creek, Montana; Richard Quint, MD,

Berkeley, California; George Randt, MD, Cleveland, Ohio; Johnathon Ross, MD, Toledo, Ohio; Marc Sapir, MD, Berkeley, California; Elias Shaya, MD, Baltimore, Maryland; Harris Silver, MD, Albuquerque, New Mexico; Paul Y. Song, MD, Santa Monica, California; James Squire, MD, Seattle, Washington; Rob Stone, MD, Bloomington, Indiana; Elizabeth F. Thomas, MD, Oakland, California; Bruce Trigg, MD, Albuquerque, New Mexico; Sandra Turner, MD, New York, New York; William Ulwelling, MD, Albuquerque, New Mexico; John V. Walsh, MD, Cambridge, Massachusetts; Li-hsia Wang, MD, Berkeley, California; Daniel P. Wirt, MD, Houston, Texas.

INTRODUCTION

Few who are familiar with the facts surrounding healthcare in the United States would deny that it represents a national crisis of the greatest magnitude and urgency. Despite being the wealthiest nation in the world, the United States is one of the few Organization for Economic Cooperation and Development ("OECD") member nations that has failed to establish either a publicly-financed or a mixed public-private healthcare system that achieves universal coverage. *See* OECD, *Health at a Glance: 2011 Indicators*, 132 (visited Feb. 7, 2012) <http://www.oecd-ilibrary.org/sites/health_glance-2011-en/06/02/index.html?contentType=/ns/StatisticalPublication,/ns/Chapter&itemId=/content/chapter/health_glance-2011-53-en&containerItemId=/content/serial/19991312&accessItemIds=&mimeType=text/html> (reporting that lack of health coverage in the United States results mainly from "the increasing cost of premiums"). Approximately 50 million Americans, or one-sixth of the entire population, risk

denial of essential healthcare services because they lack private insurance and are ineligible for public programs such as Medicare and Medicaid. *See id.*; *see also U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009*, 23 (2010). In 2009, researchers from Harvard Medical School linked this lack of coverage to 45,000 deaths per year. *See* Andrew P. Wilper, Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bor and David U. Himmelstein, *Health Insurance and Mortality in US Adults*, AM. J. OF PUB. HEALTH, Vol. 99, No. 12 (Dec. 2009). Such facts demand action: healthcare reform that guarantees comprehensive coverage to every American is nothing short of a national moral obligation.

The question, however, is whether the ACA implements the necessary reform. Does it guarantee coverage to the millions of Americans who currently have none, while controlling and reducing the rising cost of healthcare? Will it save the lives of those who die each year because they cannot afford essential healthcare services? Can the individual mandate guarantee that Americans receive such services, when private insurers have a profit incentive to deny them?

The best available evidence suggests that the ACA will not and cannot achieve these fundamental goals. According to the Government's own estimates, in 2019, five years after the individual mandate takes effect, 23 million will remain uninsured. *See D.W. Elmendorf, et al., "Letter to Nancy Pelosi,"* CONGRESSIONAL BUDGET OFFICE (March 20, 2010) (visited Jan. 26, 2012) <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>. Further, the ACA does little to reduce the cost of healthcare

administration, which accounts for 31 percent of all health spending in the United States. *See* Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Healthcare Administration in the United States and Canada*, NEW ENG. J. MED., Vol. 349, No. 8, 772 (August 21, 2003). Instead, it entrenches, by force of federal law, the private insurance companies that comprise the greatest source of administrative waste in the current system. *See id.* at 771 (reporting that average overhead of private insurers in the United States was 11.7 percent, compared to 3.6 percent for the single payer Medicare system and 1.3 percent for Canada's single payer system). In 1999 alone, such waste amounted to $209 billion. *See id.* at 772.

Perhaps most important, the ACA's reliance on private, for-profit insurance companies to finance the delivery of healthcare institutionalizes a fundamental defect of the current system, which is that these corporations have a perverse profit incentive to deny healthcare to those who need it. Although the Act bars private insurers from denying coverage based upon a person's medical condition or history, 42 U.S.C.A. 300gg-1, 300gg-3, 300gg-4(a) (the "guaranteed-issue provision"), and from charging higher premiums based on a person's medical condition or history, 42 U.S.C.A. 300gg(a)(1), 300gg-4(b) (the "community-rating provision"), these provisions do not address the inherent tension arising from the private insurers' incentive to deny healthcare to those who must purchase insurance, or pay a fine, as required by the individual mandate. 26 U.S.C.A. 5000A. Thus, private insurance companies are likely to continue to maximize profits by denying healthcare, even after these provisions take effect. *See*, *e.g.*, Tom Wilemon,

High-Deductible Health Plans on Rise, THE TENNESSEAN (Dec. 27, 2011) (reporting that employer-based health plans increasingly require workers to pay $1,200-$5,000 deductibles before filing health insurance claims).

These concerns are borne out by the experience of Massachusetts' Health Care Reform Act ("HCRA"), which was enacted in 2006, and served as the model for the ACA. Like the ACA, the goal of the HCRA was not necessarily to achieve universal coverage, but to expand coverage by filling gaps in existing healthcare systems, and by requiring residents to purchase insurance from private insurance companies. The HCRA thus suffers the same key defects as the ACA: it fails to address the waste inherent in a system of private insurers spending separately on billing, marketing and other administrative costs, and its individual mandate requires the uninsured – an overwhelmingly poor segment of the population – to buy insurance they cannot afford, or to buy "nearly worthless stripped down policies that represent coverage in name only." Steffie Woolhandler and David U. Himmelstein, *Massachusetts Health Reform Bill: A False Promise of Universal Coverage*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (April 5, 2006) (visited Feb. 7, 2012) <http://www.pnhp.org/news/2006/april/massachusetts_health.php.>

The inevitable results of the HCRA's inherent defects are now clear. In September 2011, approximately 370,000 Massachusetts residents – or 5.6 percent of the state's population – had no health insurance. *See* Rachel Nardin, Assaad Sayah, Hermione Lokko, Steffie Woolhandler and Danny McCormick, *Reasons Why Patients Remain Uninsured*

After Massachusetts' Health Care Reform: A Survey of Patients at a Safety-Net Hospital, J. OF GEN. INTERNAL MED. (Sept. 16, 2011). Researchers found the uninsured came predominantly from the state's working poor – those who had jobs but could not afford health insurance, and did not qualify for state assistance under the HCRA. *See id.* Consequently, while the HCRA increased the percentage of Massachusetts residents who are insured, it did nothing to lower the number of bankruptcy filings caused in whole or part by medical bills. *See* David U. Himmelstein, Deborah Thorne and Steffie Woolhandler, *Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?* AM. J. OF MED., Vol. 124, No. 3 (March 2011). Perhaps most revealing, Massachusetts voters have expressed strong opposition to the HCRA's individual mandate, and strong support for replacing it with a single payer system. In the November 2008 elections, local ballot initiatives directing state legislators to support "legislation creating a cost-effective single payer health insurance system that is available to all residents, and [to] oppose laws penalizing those who fail to obtain health insurance" passed in all ten districts where they appeared, with the overall support of approximately 73 percent of voters. *See* Press Release, *Single Payer Ballot Question Passes By Landslide in Ten Districts*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (Nov. 5, 2008) (visited Feb. 7, 2012) <http://www.pnhp.org/news/2008/november/single_payer_ballot_.php>. In the next election cycle, similar ballot initiatives favoring a single payer system and opposing the HCRA's individual mandate passed in all fourteen districts where they appeared. *See* Benjamin Day, *Single Payer Ballot Questions Pass in All Fourteen*

Massachusetts Districts!, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (NOV. 3, 2010) (visited Feb. 7, 2012) <http://pnhp.org/blog/2010/11/03/single-payer-ballot-questions-pass-in-all-fourteen-massachusetts-districts/>.

The impact of failed healthcare reforms is ultimately felt most keenly by the end-users in the healthcare system – those who become sick or injured and incur medical bills. On average, therefore, successful reforms that ensure quality, affordable coverage ought to be popular with the general public. Yet, only 32 percent of insured Americans under the age of 65 rate their coverage by private insurance companies as "excellent," whereas 51 percent of seniors, most of whom are covered by the single payer Medicare system, give their coverage an "excellent" rating. *See* Robert J. Blendon and John M. Benson, *The Public's Views About Medicare and the Budget Deficit*, NEW. ENG. J. OF MED., e8(1) (July 13, 2011) (visited Feb. 7, 2012) <http://www.nejm.org/doi/pdf/10.1056/NEJMp1107184>. Further, a majority of Americans, and a majority of physicians, consistently express support for adoption of a national, publicly-financed single payer system. *See*, *e.g.*, *Quinnipiac University Polling* (April 2, 2008) <http://www.quinnipiac.edu/institutes-and-centers/polling-institute/presidential-swing-states-%28fl-oh-and-pa%29/release-detail?ReleaseID=1164> (visited Feb. 7, 2012) (reporting that 64 percent of respondents say "it's the government's responsibility to make sure that everyone in the United States has adequate healthcare"); *Poll Shows Strong Public Support For Range of Health Practices*, WALL STREET JOURNAL (Oct. 20, 2005) <http://online.wsj.com/article/SB112973460667273222.html> (visited Feb. 7, 2012)

(reporting that 75 percent of respondents in Harris Interactive poll support "universal health insurance"); *Fear and Loathing at the Democratic Convention*, FAIRNESS & ACCURACY IN REPORTING (July/Aug. 1988) (visited Feb. 7, 2012) <http://www.fair.org/index.php?page=3633> (reporting that 78 percent of respondents in *New York Times / CBS* poll say "government should guarantee medical care to everyone"). By contrast, large majorities of Americans consistently disapprove of the individual mandate. *See*, *e.g.*, *Kaiser Health Tracking Poll – January 2012*, KAISER FAMILY FOUNDATION (visited Jan. 27, 2012) <http://www.kff.org/kaiserpolls/8274.cfm> (reporting that 67 percent of respondents had unfavorable view of the individual mandate).

In spite of all the evidence indicating that the individual mandate will not and cannot solve the United States' healthcare crisis, the Government contends that the provision is not only "reasonable" but also "necessary" to its broader regulation of the national healthcare market. Brief for Petitioners ("Pet. Br.") 18-19. In particular, the Government contends that the individual mandate is "key to the viability of the Act's guaranteed-issue and community-rating provisions." Pet. Br. 18. But while it might be true that these provisions will adversely impact private insurers' profits, and that the individual mandate offsets this adverse impact by guaranteeing the private insurers a large stream of new customers who are required by law to purchase insurance, that is not sufficient to render the individual mandate constitutional. If it were, Congress could "reform" any private industry – whether it be automobiles, coal, pharmaceuticals or any other – by enacting legislation requiring every that American purchase the industry's

goods or services in exchange for some perceived public good the industry provides. Yet Congress has never before enacted such a mandate. And contrary to the Government's contention, there is nothing unique or exceptional about healthcare markets, such that Congress cannot regulate them effectively without requiring that citizens purchase insurance from private insurance companies. Medicare and the VHA stand as living testaments to that fact. The evidence set forth herein therefore supports the States' position that the individual mandate exceeds the limits of Congress's power to regulate interstate commerce.

SUMMARY OF ARGUMENT

Despite its failure to cite any prior case in which Congress has compelled citizens to purchase goods or services from a private party, the Government asserts, as a primary tenet of its position, that the individual mandate is "plainly constitutional," because Congress "unquestionably" had power to enact the ACA, and Congress deemed the individual mandate "necessary" to make its reforms effective. Pet. Br. 24-25. This assertion misconstrues the nature of the power conferred by the Commerce Clause and the Necessary and Proper Clause. None of the cases cited by the Government hold that Congress may enact any regulation it deems necessary to a larger statutory scheme, as the Government contends. Instead, these cases recognize that Congress may regulate an activity if its power to regulate interstate commerce would otherwise be thwarted or obstructed.

The failure of Americans to purchase health insurance from private insurance companies does not in any way obstruct the power of Congress to regulate

the national healthcare market. As Medicare and the VHA demonstrate, Congress is capable of regulating healthcare markets effectively, without compelling citizens to purchase insurance from private insurance companies, by implementing single payer systems. Both Medicare and the VHA outperform the system of private insurers on which the ACA builds and expands, by guaranteeing universal and comprehensive coverage of the eligible population, while also controlling costs. The success of these single payer systems suggests that Congress could achieve similar results nationwide by implementing a national, publicly-financed single payer insurance.

ARGUMENT

I. The Government Misconstrues the Nature of the Commerce Power By Asserting That Congress May Enact Any Provision It Deems Necessary to a Larger Regulatory Scheme.

A. Congress Does Not Determine the Limits of Its Own Power to Regulate Interstate Commerce.

To support its view that the individual mandate is a valid exercise of the commerce power, the Government relies primarily on language it quotes from a footnote in *Hodel* v. *Indiana*, 452 U.S. 314 (1981). A statutory provision is permissible, the Government asserts, if it is "'an integral part of [a] regulatory program and…the regulatory scheme when considered as a whole' is within the commerce power." Pet. Br. 25 (quoting *Hodel*, 452 U.S at 329 n.17 (citing *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S.

241, 262 (1964), *Katzenbach* v. *McClung*, 379 U.S. 294, 303-304 (1964), *Perez* v. *United States*, 402 U.S. 146, 154-156 (1971), *Wickard* v. *Filburn*, 317 U.S. 111, 127-128 (1942), and *United States* v. *Darby*, 312 U.S. 100, 123 (1941)). Citing a congressional finding that the individual mandate is in fact "an essential part of [a] larger regulation of economic activity," the Government thus concludes that the provision is constitutional. Pet. Br. 29 (citation omitted). In the Government's view, the individual mandate is merely a "policy choice" entrusted to Congress, "and the Court should respect it." Pet. Br. 24.

As a threshold matter, the Government's partial quotation of the footnote in *Hodel* is selective and misleading. The Court did not conclude, as the Government suggests, that the enactment of a "complex regulatory program" effectively shields its individual provisions from constitutional review. Pet. Br. 25. Rather, the language the Government quotes must be understood in the context of the preceding language, which the Government omits. To sustain the constitutionality of a complex regulatory program, the Court clarified, it is not necessary to show "that every single facet of the program is independently and directly related to a valid congressional goal." *Hodel*, 452 U.S at 329 n.17. But this does not mean that the Court must instead treat every provision of a complex regulatory scheme as a "policy choice" entitled to deference. If that were the case, impermissible regulations could escape scrutiny simply because they were part of a larger statutory scheme.

Where Congress seeks to regulate activity on the ground that it has substantial effects on interstate commerce, the power of Congress to reach the activity

turns on whether, in the absence of federal regulation, the activity would "thwart the regulatory power granted by the Commerce Clause." *United States* v. *Wrightwood Dairy Co.*, 315 U.S 110, 119 (1942). To the extent that it would, Congress has power, pursuant to the Necessary and Proper Clause, to enact such regulations as are "necessary and appropriate to make the regulation of the interstate commerce effective." *Id.* at 121; *see Gonzales* v. *Raich*, 545 U.S. 1, 34 (2005) (Scalia, J. concurring). But whether a regulation is in fact necessary and proper is not a determination for Congress alone to make. Rather, this Court conducts an "exacting" review in such cases, which requires that the regulated activity be shown to have "a tangible link to commerce, not a mere conceivable rational relation." *United States* v. *Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring).

This conclusion is consistent with the Framers' understanding of the meaning and purpose of the Necessary and Proper Clause. They regarded it as merely "declaratory of a truth" inherent in the Constitution – that any enumerated power granted to Congress includes the power to "pass all laws necessary and proper to carry it into effect." THE FEDERALIST NO. 33, at 2 (Alexander Hamilton) (Clinton Rossiter ed., 1961); *see also* THE FEDERALIST NO. 44, at 6 (James Madison) (the Necessary and Proper Clause embodies the axiom that "wherever a general power to do a thing is given, every particular power necessary for doing it is included"). The Framers also anticipated, however, that Congress might "misconstrue" the broad language of the Necessary and Proper Clause, "and exercise powers not warranted by its true meaning." THE FEDERALIST NO. 44, at 6. In such cases, the Framers did not believe that the Court

should simply defer to Congress. Rather, they concluded that "the success of the *usurpation* will depend upon the executive and judiciary departments, which are to expound and give effect to the legislative acts." *Id.* at 7 (emphasis added). In other words, Congress cannot be permitted to determine the limits of its own powers, because Congress is capable of making policy choices that exceed those powers. *See*, *e.g.*, *United States* v. *Morrison*, 529 U.S. 598 (2000) (striking down federal legislation providing civil remedy for gender-motivated violence); *United States* v. *Lopez*, 514 U.S. 549 (1995) (striking down federal legislation prohibiting possession of firearms near public schools). The complete lack of precedent for the individual mandate suggests that this is one such case.

B. The Cases Cited By the Government Do Not Support the Sweeping New Power It Asserts in This Case.

Neither *Hodel* nor the string of cases cited in the footnote on which the Government relies support the conclusion that the commerce power permits Congress to enact any regulation it finds necessary to the viability of a larger scheme regulating interstate commerce. Instead, the footnote in *Hodel* refers to a line of cases "permitting the regulation of intrastate activities which in a substantial way *interfere with or obstruct the exercise of the granted power*" to regulate interstate commerce. *Gonzales*, 545 U.S. at 36 (Scalia, J. concurring) (emphasis added) (quoting *Wrightwood Dairy Co.*, 315 U.S at 119). In *Wrightwood Dairy*, for example, the Court upheld federal regulation of the price of milk produced and marketed exclusively within a single state, because competition from such milk would otherwise "tend seriously to break down

price regulation" of milk produced for the interstate market. *See Wrightwood Dairy Co.*, 315 U.S at 120. Because Congress could not effectively regulate the price of milk produced for the interstate market unless it also regulated the price of milk produced for intrastate markets, the commerce power permitted Congress to reach the purely intrastate activity. *See id.* The cases cited in the *Hodel* footnote follow the same reasoning.

In *Darby*, the Court upheld federal labor standards imposed on employees engaged in the production of goods for interstate commerce, even though the goods were manufactured intrastate. To prevent Congress from reaching such conduct, the Court recognized, would be to "deny the power of Congress to prohibit shipment in interstate commerce of [goods] produced for interstate commerce under the proscribed substandard labor conditions." *Darby*, 312 U.S. at 112. Because Congress had the power to enact such a prohibition, Congress also had the power to enact regulations necessary to ensure that its enforcement would not be frustrated. *See id.*

Similarly, in *Heart of Atlanta Motel*, the Court upheld Title II of the Civil Rights Act of 1964, which prohibited racial discrimination by hotels and motels engaged in interstate commerce. Because such discrimination "impedes interstate travel," and the commerce power includes the power to remove "obstruction[s] to interstate commerce," Congress could regulate the activity. *Heart of Atlanta Motel*, 379 U.S. at 253, 257. The Court applied the same reasoning in *Heart of Atlanta Motel's* companion case, *Katzenbach*, which upheld the same prohibition as applied to restaurants with substantial ties to

interstate commerce. *See Katzenbach*, 379 U.S. at 298-99. The only activities beyond the reach of Congress, the Court explained, are those that are "completely within a particular State, which do not affect other States, and with which *it is not necessary to interfere, for the purpose of executing some of the general powers of the government*." *Id.* at 302 (quoting *Gibbons* v. *Ogden*, 9 Wheat. 1, 22 U. S. 195 (1824) (emphasis added)).

In *Perez*, the Court upheld a regulation prohibiting the practice of "loansharking," on the ground that the activity was one of the principal means by which organized crime "syphons funds from numerous localities to finance its national operations." *Perez*, 402 U.S. at 157. If Congress could not reach the activity, the Court reasoned, it could not effectively regulate "organized interstate crime." *Id.* Even *Wickard*, which is generally considered the Court's most expansive Commerce Clause holding, was expressly predicated on the conclusion that if Congress could not regulate the growing of wheat for home consumption, such activity "would have a substantial effect in *defeating and obstructing* its purpose to stimulate trade therein at increased prices." *Wickard*, 317 U.S. at 129.

Hodel itself is no different. In that case, the Court upheld provisions of the Surface Mining Control and Reclamation Act of 1977, which required that coal mining operations take measures to protect the environment in which they operate. *See Hodel*, 452 U.S. at 321-329. In order "to ensure that production of coal for interstate commerce would not be at the expense of agriculture, the environment, or public health and safety," the Court reasoned, Congress could

regulate the purely intrastate activities of coal mine operators. *Id.* at 329.

In sum, each of the foregoing cases upon which the Government relies upheld federal legislation regulating purely intrastate activity, as a valid exercise of the commerce power, on the ground that the power of Congress to regulate interstate commerce would be thwarted or obstructed if it could not reach the intrastate activity. By contrast, the activity regulated by the individual mandate does not in any way obstruct the power of Congress to regulate the national healthcare market. As Medicare and the VHA demonstrate, Congress not only can, but actually does regulate healthcare markets effectively, without requiring that citizens purchase health insurance from private insurance companies. Nothing prevents Congress from similarly regulating the national healthcare market. Consequently, the individual mandate cannot be sustained on the ground that it is necessary to the effective regulation by Congress of the national healthcare market.

II. The Success of Single Payer Systems Currently Operating in the United States Demonstrates That Congress Can Regulate Healthcare Markets Effectively Without Requiring That Citizens Purchase Health Insurance From Private Insurance Companies.

A. Medicare and the Veterans Health Administration Are Both Single Payer Systems That Achieve Universal Coverage of the Eligible Population While Controlling Costs.

The Government's contention that Congress cannot effectively regulate the national healthcare market unless it has power to require that citizens purchase health insurance from private insurance companies is belied by the fact that Congress already does effectively regulate healthcare markets by implementing single payer systems, which provide universal coverage to certain subsets of the population. Medicare and the VHA are both examples of such systems. Each one outperforms the system of private insurers on which the ACA builds and expands by achieving universal coverage of the eligible population while controlling costs.

Congress created Medicare by amending the Social Security Act of 1935. President Lyndon B. Johnson signed the amendments into law on July 30, 1965. Medicare provides public health insurance to all citizens and persons who have been legal residents of the United States for at least five years, aged 65 or older, and to others who are permanently disabled or have certain other conditions. *See Who Is Eligible for*

Medicare? (visited Feb. 7, 2012) <http://questions.medicare.gov/app/answers/detail/a_id/10>. Medicare is a single payer system because it relies on a single government entity to process all billing and administrative tasks, while relying on private sector hospitals, doctors and caregivers to provide healthcare services. *See* Fact Sheet, *The Case for an Improved Medicare for All*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (visited Feb. 7, 2012) <http://www.pnhp.org/sites/default/files/docs/2011/Improved-Medicare-for-All-Fact-Sheet.pdf>. Medicare Part A provides hospital insurance, and Part B provides medical insurance. *See Who Is Eligible for Medicare?*, *supra*. Medicare Part A is provided to those eligible without premiums; Part B requires the payment of a premium. *See id.*

As of January 2008, Medicare provided coverage to 44 million Americans. *See* Lisa Potetz, *Financing Medicare: An Issue Brief*, KAISER FAMILY FOUNDATION, 1 (Jan. 2008) (visited Feb. 7, 2012) <http://www.kff.org/medicare/upload/7731.pdf>. It is the nation's largest single health insurance program, and finances approximately one-third of all hospital stays. *See id.* The federal government administers Medicare through a division of the Department of Health and Human Services. The program is primarily financed by a dedicated Medicare tax, premiums collected from beneficiaries, federal income taxes and a tax on Social Security benefits. *See id.* at 2. Beneficiaries also help finance the system by paying deductibles. *See id.*

While Medicare spending is increasing, the increase mainly reflects the overall increase in the nation's healthcare spending, which on average has grown 2.5 percentage points faster than the overall economy since the 1970s. *See id.* at 6. In fact, the increase in

Medicare spending per beneficiary was slightly less – 2.3 percentage points more than per capita GDP – than the increase in overall healthcare spending. *See D.W. Elmendorf, "Letter to Paul Ryan,"* CONGRESSIONAL BUDGET OFFICE, 10 (Jan. 27, 2010) (visited Feb. 7, 2012) <http://www.cbo.gov/ftpdocs/108xx/doc10851/01-27-Ryan-Roadmap-Letter.pdf>. The increase in Medicare spending therefore is not attributable to "failings in the program." *See* Potetz, *Financing Medicare*, *supra*, at 6. And while certain factors unique to Medicare, such as the aging population it serves, also contribute to the spending increase, administrative costs are "not a contributing factor." *Id.* at 8. Rather, Medicare's administrative costs have remained steadily low – about 2 percent of program expenditures, which covers "the cost of claims contractors and other costs incurred in the payment of benefits, collection of Medicare taxes, fraud and abuse control activities, various demonstration projects, and building costs associated with program administration." *Id.* By contrast, private insurance companies estimate that their administrative costs, including "commission, premium tax, and profit," range as high as 16.7 percent of overall spending. *See* Merrill Matthews, *Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector*, 9, COUNCIL FOR AFFORDABLE HEALTH INSURANCE (visited Feb. 7, 2012) <http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf. Perhaps most important, from the perspective of legislators faced with a choice between healthcare systems, overall Medicare spending only increased by 4.6 percent annually between 1997 and 2009, while private insurance premiums grew at a rate of 6.7 percent each year. *See National Health Expenditures Aggregate, Per Capita*

Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010, CENTERS FOR MEDICARE AND MEDICAID SERVICES (visited Feb. 7, 2012) <https://www.cms.gov/nationalhealthexpenddata/downloads/tables.pdf>.

Finally, in addition to achieving universal coverage for Americans aged 65 and older and maintaining consistently low administrative costs, Medicare is also highly rated by senior citizens who are its primary beneficiaries – 51 percent of whom give their health insurance an "excellent" rating. *See* Blendon and Benson, *The Public's Views About Medicare and the Budget Deficit*, *supra*, at e8(1).

The Veterans Health Administration is a cabinet level federal agency that provides comprehensive healthcare services to veterans of the U.S. military who received qualifying discharges or deactivation. *See Quality Initiatives Undertaken By the Veterans Health Administration*, 4, CONGRESSIONAL BUDGET OFFICE (Aug. 2009) (visited Feb. 7, 2012) <http://www.cbo.gov/ftpdocs/104xx/doc10453/08-13-VHA.pdf>. The VHA system includes 153 medical centers, 931 ambulatory care and community-based outpatient clinics, 232 readjustment counseling and outreach centers, 134 nursing homes, 50 residential rehabilitation treatment programs, and 108 comprehensive home-based care programs. *See id.* It provides eligible veterans with inpatient hospital care, outpatient care, laboratory services, pharmaceuticals, rehabilitation for a variety of disabilities and conditions, mental health counseling, and custodial care. *See id.* As of 2008, the VHA covered almost 8 million veterans. *See id.* at 5.

The federal government has provided healthcare to military veterans in some form since the Civil War. In 1996, however, Congress substantially expanded access to the modern VHA by enacting the Veterans' Health Care Eligibility Reform Act. *See id.* at 7. Unlike Medicare, the VHA is not an insurer but a provider of care – enrolled veterans receive healthcare services directly from the VHA. *See id.* The VHA nonetheless qualifies as a single payer system because a single government entity handles all billing and administrative tasks. *See generally*, Phillip Longman, *The Best Care Anywhere*, THE WASHINGTON MONTHLY (Jan. 1, 2005) (visited Feb. 7, 2012) <http://newamerica.net/publications/articles/2004/the_best_care_anywhere>.

Although the VHA had a reputation for poor quality in the 1980s and 1990s, it undertook a system-wide reform effort in the mid-1990s, which was designed to improve the VHA's efficiency, accountability, responsiveness, and quality of care. *See id.*; *see also* Congressional Budget Office, *Quality Initiatives Undertaken By the Veterans Health Administration*, *supra*, at 13. Following the reform, one study found that VHA patients received significantly better healthcare than patients covered by the Medicare fee-for-service program according to nearly all quality-of-care indicators. *See* Congressional Budget Office, *Quality Initiatives Undertaken By the Veterans Health Administration*, *supra*, at 13 (citing Ashish K. Jha et al., *Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care*, NEW ENG. J. OF MED., Vol. 348, No. 22, 2218-2227 (May 29, 2003). For some conditions, between 93 and 98 percent of VHA patients received "appropriate care" as defined by clinical guidelines, compared to a

high rating of 84 percent for Medicare. *See id.* Another study found that VHA patients in the late 1990s received healthcare that was "superior" to a nationally representative sample of the population. *See id.* (citing Steven M. Asch et al., *Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample*, ANN. OF INT. MED., Vol. 141, No. 12, 938-945 (Dec. 21, 2004)). At the same time, the Congressional Budget Office has concluded that the VHA achieved a "substantial degree of cost control" compared with Medicare from 1999 to 2007. *See id.* at 33.

As with Medicare, the VHA is rated higher by the population it covers than are hospitals in the private sector. *See* Kristen Jensen, *Vets Loving Socialized Medicine Show*, BLOOMBERG (Oct. 2, 2009) (visited Feb. 7, 2009) <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aLIc5ABThjBk>. In a 2008 survey by the American Customer Satisfaction Index, the VHA received a satisfaction rating of 85 percent for inpatient care, compared with 77 percent for private hospitals. *See id.*

B. The System of Private Insurers on Which the ACA Builds and Expands Is More Expensive and Less Efficient Than Single Payer Systems.

Congress could have addressed the United States' healthcare crisis by choosing from among several legislative alternatives that would guarantee universal coverage while reducing and controlling costs. For example, Congress could have enacted legislation modeled on Medicare, which would establish a national, publicly-financed single payer insurance that

relies on private hospitals, doctors and caregivers to provide healthcare services. *See supra* Part II.A. Congress also could have enacted legislation modeled on the VHA, which would establish an integrated national healthcare system in which public entities handle both administration and provision of healthcare services. *See id.* Or Congress could have enacted legislation establishing a mixed public-private system, which would build and expand on the best aspects of the disparate healthcare systems currently operating in the United States. In fact, such bills have been introduced in Congress, including at least one that was pending in the Senate at the same time as the ACA. *See* S. 703 111th Cong. (2009) (the "American Health Security Act") (visited Feb. 6, 2012) <http://thomas.loc.gov/cgi-bin/query/D?c111:8:./temp/~mdbsElLnIw::>; H.R. 676 108th Cong. (2003-04) (the "Expanded and Improved Medicare for All Act") (visited Feb. 6, 2012) <http://thomas.loc.gov/cgi-bin/query/F?c108:3:./temp/~mdbshmY9r5:e1446>.

Studies conducted by the nonpartisan General Accounting Office and the nonpartisan Congressional Budget Office have consistently concluded that if a national single payer system were implemented in the United States, administrative cost-savings alone would be enough to guarantee universal coverage without increasing overall healthcare spending. *See*, *e.g.*, Charles A. Bowsher, *Canadian Health Insurance: Lessons for the United States*, GENERAL ACCOUNTING OFFICE (June 4, 1991) (visited Feb. 4, 2012) <http://www.gao.gov/assets/110/103905.pdf>; Robert D. Reischauer, et al., *Universal Health Insurance Coverage Using Medicare's Payment Rates*, CONGRESSIONAL BUDGET OFFICE (Dec. 1991) (visited Feb. 4, 2012) <http://www.cbo.gov/ftpdocs/76xx/doc

7652/91-CBO-039.pdf>; CBO Staff Memorandum, *Single-Payer and All-Payer Health Insurance Systems Using Medicare's Rates*, CONGRESSIONAL BUDGET OFFICE (April 1993) (visited Feb. 4, 2012) <http://www.cbo.gov/ftpdocs/64xx/doc6442/93doc171.pdf>. The Congressional Budget Office reached similar conclusions in its studies of specific single payer bills previously introduced before Congress. For example, a 1991 U.S. House bill modeled on the Canadian system, which would establish a single payer system to be implemented in 1993, was estimated to increase healthcare expenditures slightly at first, but to reduce overall spending 9 percent by 2000. *See* Paul Van de Water, *Estimates of Healthcare Proposals From the 102nd Congress*, 21-28, CONGRESSIONAL BUDGET OFFICE (July 1993) (visited Feb. 4, 2012) <http://www.cbo.gov/ftpdocs/64xx/doc6432/ 93doc159.pdf>; *see also* CBO Analysis, *American Health Security Act of 1993*, CONGRESSIONAL BUDGET OFFICE (analyzing Senate version of same bill) (visited Feb. 4, 2012) <http://www.cbo.gov/ftpdocs/79xx/doc7946/93doc07b.pdf>.

Rather than model the ACA on the proven success of single payer systems such as Medicare and the VHA, Congress instead chose to build and expand on the system of private insurers currently in place in the United States. This system is among the least efficient of any healthcare system currently operating in an OECD member nation. *See* David Carey, Bradley Herring and Patrick Lenain, *Healthcare Reform in the United States*, OECD Econ. Dept. Working Paper No. 665 (Feb. 6, 2009); Isabelle Joumard, Christophe André and Chantal Nicq, *Healthcare Systems: Efficiency and Institutions*, OECD Econ. Dept. Working Paper No. 769, 6 (May 19, 2010). In 2009,

healthcare expenditures accounted for 17.4 percent of GDP in the United States, compared with only 9.6 percent in the average OECD nation. *See* OECD, *Why Is Health Spending in the United States So High?*, 1 (visited Feb. 7, 2012) <http://www.oecd.org/dataoecd/12/16/49084355.pdf>. Measured per capita, healthcare expenditures in the United States "are by far the highest among OECD countries," and would be enough in most others "for government to provide universal primary health insurance." *See* David Carey, et al., *Healthcare Reform in the United States*, *supra*, at 11. Yet the United States is among the few OECD nations that fail to cover a large percentage of the population (Mexico and Turkey are the others). *See* Joumard, André and Nicq, *Healthcare Systems*, *supra*, at 6.

Several factors contribute to the inefficiency of the United States' healthcare system, but the most significant is spending on healthcare administration. *See* OECD, *Why Is Health Spending in the United States So High?*, *supra*, at 3 (reporting that administrative costs in the United States are more than two-and-a-half times the average for all OECD nations). This category not only includes "activities such as billing, denial of claims, supervision of copayments and deductibles," but also "scrutiny of preexisting conditions that disqualify people from care, and exorbitant salaries for executives (in some cases totaling between $10 million and $20 million per year)." Howard Waitzkin, *Selling the Obama Plan: Mistakes, Misunderstandings and Other Misdemeanors*, AM. J. OF PUBLIC HEALTH, Vol. 100, No. 3, 398 (March 2010). Thus, if a national single payer system were implemented in the United States, it could realize dramatic cost-savings both by streamlining administrative processes, and by

eliminating the profit incentive that drives many practices of the private insurance companies that the ACA entrenches by force of federal law. *See id.*; Oliver Fein, *Keep the Single Payer Vision*, MEDICAL CARE, Vol. 48, No. 9, 760 (Sept. 2010).

CONCLUSION

For the reasons stated above and in the brief of the respondent States, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

Oliver B. Hall
Counsel of Record
1835 16th Street NW #5
Washington, DC 20009
(617) 953-0161
oliverbhall@gmail.com

Counsel for Amici Curiae