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

---

BRIEF OF THE CALIFORNIA ENDOWMENT AS *AMICUS CURIAE* SUPPORTING PETITIONERS

KATHLEEN M. SULLIVAN
Counsel of Record
WILLIAM B. ADAMS
DAVID B. SCHWARTZ
QUINN EMANUEL URQUHART & SULLIVAN, LLP
51 Madison Avenue
22nd Floor
New York, NY 10010
(212) 849-7000
kathleensullivan@quinnemanuel.com

Counsel for Amicus Curiae

October 28, 2011

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	5
I. REVIEW IS WARRANTED BECAUSE THE MINIMUM COVERAGE REQUIREMENT IS A PROPER EXERCISE OF CONGRESS'S COMMERCE CLAUSE POWER	5
A. An Individual's Uninsured Status Creates A "Tangible Link To Commerce"	5
B. Uncompensated Care Also Substantially Affects Interstate Commerce	9
II. REVIEW IS WARRANTED TO REAFFIRM THAT PROVISIONS LIKE THE MINIMUM COVERAGE REQUIREMENT ARE WITHIN CONGRESS'S AUTHORITY WHEN THEY ARE AN ESSENTIAL PART OF A COMPREHENSIVE REGULATORY SCHEME	12
CONCLUSION	16

TABLE OF AUTHORITIES

CASES Page

Florida v. United States Dep't of Health & Human Services,
648 F.3d 1235 (11th Cir. 2011)...3, 4, 8, 11, 13, 15

Gonzales v. Raich,
545 U.S. 1 (2006) 4, 5, 8, 11, 12, 13, 14

McCulloch v. Maryland,
17 U.S. (4 Wheat.) 316 (1819) 12, 13, 15

Sabri v. United States,
541 U.S. 600 (2004) 15

United States v. Comstock,
130 S. Ct. 1949 (2010) 4, 5, 8, 12, 13, 14, 15

United States v. Lopez,
514 U.S. 549 (1995) 8, 9, 11, 13

United States v. Se. Underwriters Ass'n,
322 U.S. 533 (1944) 5, 12

STATUTES/RULES

42 U.S.C.A. § 1395dd(a) 7, 9

42 U.S.C.A. § 18091(a)(2)(F) 9, 10, 11

42 U.S.C.A. § 18091(a)(2)(I) 3, 11, 15

Patient Protection and Affordable Care Act,
Pub. L. No. 111-148, 124 Stat. 119 (2010)... 1

§ 1001 2

§ 1201 2

§ 1311 2

§ 1312 2

TABLE OF AUTHORITIES—Continued

Page

§§ 1401-1421 2

§ 1511 1

§ 1513 2

§ 2001 1

§ 2501 2

§ 4104 2

Health Care & Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). 1

OTHER AUTHORITIES

Amicus Brief of the Governor of Washington Christine Gregoire in Support of Defendants/Appellants, *Florida v. U.S. Dep't of Health & Human Services*, 648 F.3d 1235 (11th Cir. 2011) 11

California Hospital Ass'n, *A Report on California Hospitals, the Economy, and Health Care Reform*, Aug. 2009 .... 6, 7

Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, June 16, 2010..... 14

Families USA, *Hidden Health Tax: Americans Pay a Premium*, May 2009..................7, 9, 10

Ben Furnas & Peter Harbage, *The Cost Shift from the Uninsured* (Center for American Progress), Mar. 24, 2009 10

TABLE OF AUTHORITIES—Continued

Page

Jonathan Gruber, *Health Care Reform Is A "Three-Legged Stool"* (Center for American Progress), Aug. 2010............................3, 11, 14, 15

Jonathan Gruber, *Health Care Reform without the Individual Mandate* (Center for American Progress), Feb. 2011 .... 14, 15

Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System*, HEALTH POLICY PROGRAM ISSUE BRIEF #3 (New America Foundation), Dec. 2006 ....7, 9, 10

Shana Alex Lavarreda & Livier Cabezas, *Two Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform*, UCLA HEALTH POLICY RESEARCH BRIEF, Feb. 2011...........2, 6, 14

Peter Long & Jonathan Gruber, *Projecting the Impact of the Affordable Care Act on California*, 30:1 HEALTH AFFAIRS 63 (Jan. 2011)... 14

Elizabeth Mendez, *State of the States: Texans Most Likely to Be Uninsured, Mass. Residents Least* (Gallup), Mar. 11, 2011... 6

Elizabeth Mendez, *State of the States: Texas and Mass. Still at Health Coverage Extremes in U.S.* (Gallup), Sept. 6, 2011..... 6

BRIEF OF THE CALIFORNIA ENDOWMENT AS *AMICUS CURIAE* SUPPORTING PETITIONERS

INTEREST OF *AMICUS CURIAE* [1]

The California Endowment ("TCE") has an important interest in the questions presented by this case and the related cases challenging the constitutionality of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).[2] TCE is a private foundation committed to the expansion of affordable, quality health care for all Californians, with an emphasis on providing health care to underserved and low income communities. As part of this goal, TCE funds a variety of social science and public policy research in an effort to show both policymakers and health care consumers the benefits of expanding the scope of health insurance.

TCE thus supports the enactment and implementation of the ACA. The ACA is a comprehensive, multifaceted legislative scheme aimed at achieving near-universal and affordable health care coverage for every American citizen. It expands Medicaid coverage, ACA § 2001; requires large employers to provide health care coverage for their workers, ACA §§ 1511,

---

[1] Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amicus curiae* and its counsel, made any monetary contribution toward the preparation or submission of this brief. On October 7 and 11, 2011, all parties filed letters with the Clerk of Court reflecting their blanket consent to the filing of *amicus* briefs; in light of Supreme Court Rule 37.2(a), *amicus curiae* nonetheless thereafter notified counsel of record for all parties of its intent to file this brief.

[2] As amended by the Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

1513; creates new health benefit exchanges for individuals and small businesses, ACA §§ 1311, 1312; provides tax credits to allow a broad range of individuals and families to purchase health insurance, ACA §§ 1401-1421; eliminates Medicare copayments for a wide variety of preventive services (*e.g.*, screening for cancer), ACA § 4104; and strengthens the Medicare Part D prescription drug program by filling in the "donut hole," ACA § 2501.

An essential keystone of this comprehensive regulatory program is the ACA's reform of the interstate health insurance industry. The ACA requires insurers to accept all applicants, regardless of pre-existing conditions, and prohibits insurance companies from charging premiums based on an individual applicant's medical condition. ACA §§ 1001, 1201. These health insurance reforms, working in concert with the ACA's other regulatory changes, will vastly expand eligibility for health care: TCE-funded research shows that, in California alone, the ACA will enable almost 5.9 million of California's nearly 7.1 million non-elderly uninsured individuals to purchase and maintain affordable health insurance.[3]

The ACA also recognizes that its reforms of the interstate health insurance industry will work only if individuals are required to have health insurance before they require medical care. As Congress expressly found, the ACA's minimum coverage requirement ("MCR") will minimize the "adverse selection" effect of healthy individuals foregoing coverage,

---

[3] Shana Alex Lavarreda & Livier Cabezas, *Two Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform* 1, UCLA HEALTH POLICY RESEARCH BRIEF, Feb. 2011, http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=478.

which will both broaden the health insurance risk pool and lower health insurance premiums. 42 U.S.C.A. § 18091(a)(2)(I). The MCR is critical to the ACA's reform of the interstate health insurance market: in the absence of the MCR, Congress's goal of providing near universal health care will be obstructed, creating a potential "death spiral" of high prices and limited coverage.[4]

TCE therefore has a strong interest in supporting the constitutionality of the MCR, and the ACA in general. The Eleventh Circuit's ruling in *Florida v. United States Department of Health & Human Services*, 648 F.3d 1235 (11th Cir. 2011), throws the efficacy of the ACA into question and thus disrupts TCE's efforts to help effectively implement and publicize the ACA. TCE submits this brief to provide the Court with additional justifications and empirical support for the petitioners' arguments that this Court should grant the petition for a writ of certiorari.

SUMMARY OF ARGUMENT

The Eleventh Circuit's decision deserves review by this Court for numerous reasons, several of which are explained by the Government in its petition for a writ of certiorari. TCE writes to further explain two independent errors by the Eleventh Circuit that warrant this Court's review.

First, the Eleventh Circuit erred when it concluded, contrary to Congress's judgment and this Court's precedents, that the MCR is unconstitutional because it "does *not* regulate behavior at the point of

---

[4] Jonathan Gruber, *Health Care Reform Is A "Three-Legged Stool"* 2 (Center for American Progress), Aug. 2010, http://www.americanprogress.org/issues/2010/08/pdf/repealing_reform.pdf.

consumption." *Florida*, 648 F.3d at 1295. Contrary to this statement, the MCR does aim at the consumption of economic resources: it seeks to shift the point at which the uninsured and underinsured enter the health care market so that they purchase health insurance before they consume health care services at significantly higher cost than they would if insured. Empirical research, including data reflecting California's health care experience, helps demonstrate this "tangible link to commerce," which is all that is necessary under the Commerce Clause for Congress to regulate the means by which individuals consume health care. *United States v. Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring in the judgment); *accord Gonzales v. Raich*, 545 U.S. 1, 17-19 (2006).

Second, the Eleventh Circuit erred when it invalidated the MCR despite concluding that the MCR "counteract[s] the significant regulatory costs on insurance companies and adverse consequences stemming from the fully executed reforms." *Florida*, 648 F.3d at 1310. This Court's precedents teach that the Necessary and Proper Clause "empowers Congress to enact laws in effectuation of its enumerated powers that are not within its authority to enact in isolation." *Raich*, 545 U.S. at 39 (Scalia, J., concurring in the judgment); *accord Comstock*, 130 S. Ct. at 1956-57. Empirical research, including California-focused research, buttresses Congress's rational judgment that the MCR is necessary for the ACA to function properly.

ARGUMENT

I. REVIEW IS WARRANTED BECAUSE THE MINIMUM COVERAGE REQUIREMENT IS A PROPER EXERCISE OF CONGRESS'S COMMERCE CLAUSE POWER

Nearly seventy years ago, this Court explained that the Commerce Clause "power, as held by this Court from the beginning, is vested in Congress, available to be exercised for the national welfare as Congress shall deem necessary." *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 552-53 (1944). This Court continued: "No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance." *Id.* at 553. By holding that the MCR is unconstitutional because Congress chose not to regulate the health insurance and health care industries "at the point of consumption," the Eleventh Circuit ignored the key lessons of this Court's Commerce Clause jurisprudence.

A. An Individual's Uninsured Status Creates A "Tangible Link To Commerce"

For a statute to constitute a valid exercise of Congress's authority under the Commerce Clause, there need only be "a 'rational basis'" for concluding that an individual's "activities, taken in the aggregate, substantially affect interstate commerce." *Raich*, 545 U.S. at 22. This "rational basis referred to in the Commerce Clause context is a demonstrated link in fact, based on empirical demonstration." *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring in the

judgment). In this case, the "tangible link to commerce," *id.*, is easily demonstrated.

Evidence from the State of California provides particularly strong confirmation of Congress's judgment. While Congress was considering legislation that ultimately became the ACA, TCE-sponsored research found that "seven million Californians reported being uninsured for all or part of 2009."[5] The recent recession has exacerbated this problem, as California's ranks of the uninsured have swelled from 18.9% of the State's population in 2008 to 21.9% of its population in 2011.[6] California currently ranks sixth highest in the Nation in terms of percentage of uninsured residents.[7]

Congress rationally could have concluded that individuals' failure to obtain health insurance is an economic choice that substantially affects interstate commerce. "Individuals without a routine source of health care often use hospital emergency departments as the entry point to primary and other health care services."[8] Indeed, "[u]ninsured adults are nearly eight times as likely as the privately insured to go

---

[5] Lavarreda & Cabezas, *supra* n.3, at 3.

[6] Elizabeth Mendez, *State of the States: Texas and Mass. Still at Health Coverage Extremes in U.S.* (Gallup), Sept. 6, 2011, http://www.gallup.com/poll/149321/texas-mass-health-coverage-extremes.aspx; Elizabeth Mendez, *State of the States: Texans Most Likely to Be Uninsured, Mass. Residents Least* (Gallup), Mar. 11, 2011, http://www.gallup.com/poll/146579/Texans-Likely-Uninsured-Mass-Residents-Least.aspx.

[7] Mendez, *supra* n.6.

[8] California Hospital Ass'n, *A Report on California Hospitals, the Economy, and Health Care Reform* 3, Aug. 2009, http://www.calhospital.org/public/report-california-hospitals-economy-and-health-care-reform (hereinafter "CHA").

without needed care due to cost," and "are nearly seven times more likely to have gone without any preventive care in the last year than insured adults."[9] "In California, the best estimates are that the average uninsured person gets less than 40 percent of the care received by the average insured person."[10] Critically, hospital emergency departments "are the *most expensive* and often the *least efficient* point of entry into the system when primary and preventive care would have helped the patient if they had been available."[11]

Exacerbating this problem is the fact that California health care providers are legally required to treat individuals who decide to consume health care in this expensive and inefficient manner. Under federal law, a California hospital must treat any uninsured who comes into its emergency room, regardless of residency or ability to pay. *See* 42 U.S.C.A. § 1395dd(a). This scheme results in California hospitals, like other hospitals nationwide, providing treatment even where it is not cost-effective to do so.

These two forces create the necessary "tangible link" between regulating the choice to forego health insurance and interstate commerce. Because the uninsured are empirically more likely to need more expensive care, and because health care providers

---

[9] Families USA, *Hidden Health Tax: Americans Pay a Premium* 4, May 2009, http://familiesusa2.org/ assets/pdfs/hidden-health-tax.pdf.

[10] Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System* 2, HEALTH POLICY PROGRAM ISSUE BRIEF #3 (New America Foundation), Dec. 2006, http://www.newamerica.net/ files/naf migration/HealthIBNo3.pdf.

[11] CHA, *supra* n.8 (emphasis added).

may not refuse to treat such individuals, Congress could rationally enact the MCR to ensure that individuals purchase health care in a more efficient and significantly less expensive manner.

The Eleventh Circuit, however, rejected this empirical logic and held that Congress may regulate the uninsured only when they "actually enter the stream of commerce and consume health care." *Florida*, 648 F.3d at 1295. This is incorrect. Congress is well within its constitutional authority under the Commerce Clause when it makes a judgment that such a time is too late: at that point, interstate commerce has already been substantially affected by uninsured individuals' use of hospital emergency departments—the *most expensive* and *least efficient* form of health care.

The Eleventh Circuit's failure to cite any authority to support its assertion is telling, because there is no basis in the Constitution or this Court's precedents to so tie Congress's hands. Rather, where there "is a demonstrated link in fact, based on empirical demonstration," *Comstock*, 130 S. Ct. at 1969 (Kennedy, J., concurring in the judgment), then "the Commerce Clause grants Congress extensive power and ample discretion to determine its appropriate exercise," *United States v. Lopez*, 514 U.S. 549, 568 (1995) (Kennedy, J., concurring); *see also Raich*, 545 U.S. at 22. This Court therefore should grant the petition in order to review the Eleventh Circuit's rejection of Congress's empirical judgment that a lack of insurance directly affects interstate commerce.

B. Uncompensated Care Also Substantially Affects Interstate Commerce

Beyond the empirical fact that uninsured individuals consume health care in the *least efficient* and *most expensive* manner possible, Congress also rationally could have found a "tangible link to commerce" based on "[t]he cost of providing uncompensated care to the uninsured[, which] was $43,000,000,000 in 2008." 42 U.S.C.A. § 18091(a)(2)(F). In rejecting Congress's conclusion as insufficient to support Commerce Clause authority, the Eleventh Circuit "return[ed] to the time when congressional authority to regulate undoubted commercial activities was limited by a judicial determination that those matters had an insufficient connection to an interstate system." *Lopez*, 514 U.S. at 574 (Kennedy, J., concurring). This Court should grant review to reaffirm the principle that measures like the MCR are justified by the substantial effects they have on interstate commerce in the health care market.

When an uninsured or underinsured individual obtains medical care—which health care providers are required to give under federal law, *see* 42 U.S.C.A. § 1395dd(a)—they consume health care services for which they cannot pay. Nationally, uninsured individuals pay for approximately 37 percent of their care; third-party sources, such as government programs and charities, pay for another 26 percent; and the remaining 37 percent, nearly $43 billion in 2008, is "uncompensated care."[12] In California alone, uncompensated care totaled $9.6 billion in 2006.[13]

---

[12] Families USA, *supra* n.9, at 2.

[13] Harbage & Nichols, *supra* n.10, at 2.

Uncompensated care must be paid somehow—"[p]roviders do not have unlimited pockets to secretly finance the health care provided to millions of uninsured (and underinsured) patients."[14] Providers thus recover these missing billions "primarily by increasing charges for those with private insurance."[15] Insurers pass these costs along to individuals and families who purchase private insurance.[16] Nationwide, "this translated into a surcharge of $368 for individual premiums and a surcharge of $1,017 for family premiums in 2008 due to uncompensated care."[17] In 2006, this "cost-shift" resulted in an additional $455 in premiums for California individuals and an additional $1,186 for California families;[18] by 2009, those costs had risen to $500 and $1,400, respectively.[19] Congress's findings are consistent with this empirical data: "[C]ost-shifting increases family premiums by on average over $1,000 a year." 42 U.S.C.A. § 18091(a)(2)(F).

Congress concluded that the MCR would help to solve these economic problems: "By significantly reducing the number of the uninsured, the [MCR], together with the other provisions of this Act, will

[14] *Id.*

[15] Families USA, *supra* n.9, at 6. Health care providers cannot turn to state and federal government programs to cover the cost, since those programs use regulations and contracts to set provider payments in advance. *Id.*

[16] *Id.*

[17] *Id.* at 7.

[18] Harbage & Nichols, *supra* n.10, at 2.

[19] Ben Furnas & Peter Harbage, *The Cost Shift from the Uninsured* 2 (Center for American Progress), Mar. 24, 2009, http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf.

lower health insurance premiums." 42 U.S.C.A. § 18091(a)(2)(F). The resulting "broad distribution of health risks in the market" substantially reduces this cost-shifting problem, decreasing premiums for all.[20] For example, one analysis estimates that the MCR will reduce premiums by over 20 percent for individuals and over 10 percent for families.[21]

Without the MCR, this cost-shifting problem would be exacerbated: as evidence from multiple States has shown, when there is a prohibition on denying coverage due to pre-existing conditions but no MCR, healthy individuals stay out of the market, creating a "death spiral" of rapidly rising insurance costs and lower rates of health coverage.[22] Congress recognized this problem, and explicitly sought to address it in enacting the MCR. 42 U.S.C.A. § 18091(a)(2)(I).

Despite this well-documented link between the problem of high percentages of uninsured individuals and the affordability of health care, the Eleventh Circuit held that, "[a]t best, we can say that the uninsured *may*, at some point in the *unforeseeable future*, create that cost-shifting consequence." *Florida*, 648 F.3d at 1302. But this Court has consistently rejected a mode of analysis where a court substitutes its own empirical judgment for Congress's. *See, e.g.*, *Raich*, 545 U.S. at 22; *Lopez*, 514 U.S. at 574

---

[20] Gruber, *supra* n.4, at 3.

[21] *See id.* at 4.

[22] *See* Amicus Brief of the Governor of Washington Christine Gregoire in Support of Defendants/Appellants 11-12, *Florida v. U.S. Dep't of Health & Human Services*, 648 F.3d 1235 (11th Cir. 2011) (describing Washington's experience of enacting health reforms without an MCR, where "the major carriers in Washington stopped selling individual plans, leading to the virtual destruction of the individual insurance market").

(Kennedy, J., concurring). Congress carefully considered and relied upon evidence of the "tangible link to commerce" that is required under this Court's precedents. *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring in the judgment). This Court should grant certiorari to review the Eleventh Circuit's decision so that the proper standard of review of Congress's empirical judgments may be reaffirmed.

II. REVIEW IS WARRANTED TO REAFFIRM THAT PROVISIONS LIKE THE MINIMUM COVERAGE REQUIREMENT ARE WITHIN CONGRESS'S AUTHORITY WHEN THEY ARE AN ESSENTIAL PART OF A COMPREHENSIVE REGULATORY SCHEME

The Eleventh Circuit's decision also warrants review for the independent reason that it limits Congress's authority under the Necessary and Proper Clause, read together with the Commerce Clause, in ways that are inconsistent with this Court's precedents. The MCR is within Congress's authority because it is an essential part of the ACA's comprehensive regulation of the interstate health insurance industry.

It is undisputed that Congress may regulate the business of insurance under its Commerce Clause authority. *Se. Underwriters Ass'n*, 322 U.S. at 552-53. Moreover, the Necessary and Proper Clause "empowers Congress to enact laws in effectuation of its enumerated powers that are not within its authority to enact in isolation." *Raich*, 545 U.S. at 39 (Scalia, J., concurring in the judgment) (citing *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 421-22 (1819)); *see also Comstock*, 130 S. Ct. at 1956 ("[T]he Necessary and Proper Clause makes clear

that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" (quoting *McCulloch*, 17 U.S. at 413, 418)). This authority applies fully where, as here, the statutory provision at issue is one of the "essential parts of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the [activity at issue] were regulated." *Raich*, 545 U.S. at 24-25 (brackets and internal quotation marks omitted) (quoting *Lopez*, 514 U.S. at 561). Congress therefore was authorized to enact the MCR as "a means that is rationally related to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956.

The Eleventh Circuit thus erred in holding that the MCR was insufficiently encompassed within Congress's authority even though it "counteract[s] the significant regulatory costs on insurance companies and adverse consequences stemming from the fully executed reforms," *Florida*, 648 F.3d at 1310. By counteracting those costs and adverse consequences, the MCR is an essential part of the larger regulatory scheme by which the ACA reforms the health care and health insurance markets.

California's recent experience with the ACA helps to illustrate the Eleventh Circuit's error. As described above and in the Government's petition, the ACA's interlocking provisions expand public provision of health care, create new health benefit exchanges, and provide subsidies for the purchase of health insurance. *See* Petition for Certiorari at 2-5, *Dep't of Health & Human Services v. Florida*, No. 11-398 (Sept. 28, 2011). TCE-funded research predicts

that these reforms will expand eligibility for over 84 percent of California's uninsured, with the vast majority of these obtaining some sort of federal or state subsidy.[23]

Yet the MCR is the critical piece necessary to getting nearly 6 million California residents to obtain health insurance. As one recent model of California's uninsured reported, "the reach of the mandate will be a key determinant of [the ACA's] success in increasing insurance coverage."[24] The Congressional Budget Office likewise concluded that, nationwide, the MCR would bring 16 million nonelderly residents into the pool of the insured.[25] Because the MCR is thus an essential cornerstone for ACA's reforms, the Eleventh Circuit's decision to strike it down "will critically undercut gains from reform."[26] Congress therefore was constitutionally authorized to enact the MCR under the Necessary and Proper Clause in conjunction with the Commerce Clause. *See, e.g.*, *Comstock*, 130 S. Ct. at 1956-57; *Raich*, 545 U.S. at 24-25; *id.* at 39 (Scalia, J., concurring in the judgment).

---

[23] Lavarreda & Cabezas, *supra* n.3, at 2 & Ex. 1.

[24] Peter Long & Jonathan Gruber, *Projecting the Impact of the Affordable Care Act on California*, 30:1 HEALTH AFFAIRS 63, 67 (Jan. 2011).

[25] Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2, June 16, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf. Other estimates put the number higher, with one finding that the MCR would be responsible for creating 24 million insured nonelderly residents. Jonathan Gruber, *Health Care Reform without the Individual Mandate* 2 (Center for American Progress), Feb. 2011, http://www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf.

[26] Gruber, *supra* n.4, at 3.

The MCR creates other economic benefits that likewise justify Congress's exercise of its authority under the Necessary and Proper Clause. The MCR is conducive to the regulation of interstate commerce because it provides significantly higher "bang for the buck," raising health insurance coverage rates by 50 to 75 percent for only a 25 to 30 percent increase in costs.[27] And by reducing cost-shifting, the MCR helps significantly lower health insurance premiums—one of the ACA's key goals, *see* 42 U.S.C.A. § 18091(a)(2)(I)—by approximately 10 percent for families and approximately 20 percent for individuals.[28] Moreover, the MCR is conducive to the prudent expenditure of public funds under the Spending Clause; Congress is entitled to legislate so that its money is spent efficiently and "not frittered away." *Sabri v. United States*, 541 U.S. 600, 605 (2004). Congress thus was empowered to enact the MCR under its longstanding authority "to enact laws that are 'convenient, or useful' or 'conducive' to [an enumerated] authority's 'beneficial exercise.'" *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 413, 418).

The Eleventh Circuit recognized that the MCR "counteract[s] the significant regulatory costs on insurance companies," *Florida*, 648 F.3d at 1310, but drew the opposite conclusion from the one this Court's precedents demand. Accordingly, this Court should grant the Government's petition so that it may consider whether the MCR is a constitutional exercise of Congress's authority under the Necessary and Proper Clause, read together with the Commerce Clause.

---

[27] Gruber, *supra* n.25, at 2.

[28] Gruber, *supra* n.4, at 4.

CONCLUSION

For the foregoing reasons, and for those stated by the petitioners, the Court should grant the petition for a writ of certiorari.

Respectfully submitted,

KATHLEEN M. SULLIVAN
Counsel of Record
WILLIAM B. ADAMS
DAVID B. SCHWARTZ
QUINN EMANUEL URQUHART & SULLIVAN, LLP
51 Madison Avenue
22nd Floor
New York, NY 10010
(212) 849-7000
kathleensullivan@quinnemanuel.com

Counsel for Amicus Curiae

October 28, 2011