No. 11-398

IN THE

Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al*.
Petitioners,

v.

FLORIDA, *et al*.
Respondents.

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

BRIEF OF *AMICI CURIAE* THE AMERICAN CANCER SOCIETY, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, AMERICAN DIABETES ASSOCIATION, AND AMERICAN HEART ASSOCIATION, SUPPORTING PETITIONERS URGING REVERSAL ON THE MINIMUM COVERAGE PROVISION ISSUE

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INTEREST OF *AMICI*[2]

The American Cancer Society ("ACS"), and American Cancer Society Cancer Action Network ("ACS CAN"), the American Diabetes Association ("ADA"), and the American Heart Association ("AHA") (collectively, "*Amici*") are the largest and most prominent organizations representing the interests of patients, survivors, and families affected by the widespread chronic conditions of, respectively, cancer, diabetes, and heart disease and stroke. These conditions result in a significant portion of the nation's health care spending.

The fight against cancer, diabetes, heart disease, and stroke requires access to affordable, quality health care and to health insurance. *Amici* therefore

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[1] *Amici* certify that this brief was authored in whole by counsel for *Amici* and no part of the brief was authored by any attorney for a party. No other person or entity made any monetary contribution to the preparation or submission of this brief.

[2] Blanket consents to the filing of filing of amicus curiae briefs in support of either party or of neither party were received from counsel for the petitioners, the Solicitor General, filed on November 15, 2011 and from counsel for Florida, et al. filed on November 22, 2011.

strongly supported patient access to care provisions of the Patient Protection and Affordable Care Act ("Affordable Care Act" or "Act") during its consideration by Congress, and desire to assist the Court in understanding why those provisions of the Act are so important to millions of cancer, diabetes, heart disease, and stroke patients and survivors, as well as their families. Because these diseases are chronic, those living with them are particularly susceptible to discrimination in the rates and terms of health insurance, or to being denied coverage altogether, due to pre-existing medical condition exclusions and adverse rating actions based on their health status. The Affordable Care Act addresses these problems, but as the United States acknowledged to the Eleventh Circuit below that "the minimum coverage provision is integral to the Act's guaranteed-issue and community-rating provisions." Brief for Appellants, *Florida v. HHS*, Nos. 11-11021 & 11-11067, at 59 (filed April 4, 2011). *Amici* therefore are gravely concerned that if the minimum coverage provision is invalidated, these important provisions may be jeopardized as well.

The ACS is the nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. The ACS has three million volunteers nationwide. The ACS seeks to reduce cancer mortality by 50 percent and cancer incidence by 25 percent by 2015. The ACS's extensive scientific findings have established that health insurance status is strongly linked to medical outcomes. Cancer patients with adequate insurance coverage are more likely to be diagnosed at an earlier stage of disease resulting in lower medical costs, more thorough treatment, better outcomes, and lower rates of death. Accordingly, the ACS identified the

lack of adequate insurance coverage as a major impediment to advancing the fight against cancer. Along with its nonpartisan advocacy affiliate, ACS CAN, the ACS strongly advocates guaranteeing all Americans adequate, available, affordable health care that is administratively simple. ACS CAN has nearly a million patient and survivor advocates nationwide, including thousands that participated in efforts supporting enactment of strong patient protections in the Affordable Care Act. During consideration of the Affordable Care Act, ACS CAN was the leading voice for cancer patients and their families seeking the inclusion of patient protections in the law.

The ADA is a nationwide, nonprofit, voluntary health organization founded in 1940, and has over 485,000 general members, 15,000 health professional members, and 1,000,000 volunteers. Its mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. The ADA is the most authoritative source for clinical practice recommendations, guidelines, and standards for the treatment of diabetes. As part of its mission, the ADA works to improve access to high quality medical care and treatment for all people with and at risk for diabetes. In seeking to prevent diabetes, protect the rights of patients, and improve access to affordable and adequate insurance for people with diabetes, and based on clear evidence that lack of health insurance leads to increased risk of diabetes complications, the ADA supported provisions in the Affordable Care Act that specifically impact people with diabetes. These include provisions to end discrimination, exclusion, and other adverse actions based on pre-existing conditions such as diabetes, to ban rescissions and caps on annual and lifetime benefits, and to develop an essential benefits package.

The AHA is the nation's oldest and largest voluntary health organization dedicated to fighting heart disease and stroke—the first and fourth leading causes of death in the United States. Since 1924, the AHA and its more than 22 million volunteers and supporters have focused on reducing disability and death from cardiovascular disease and stroke through research, education, community-based programs, and advocacy. The AHA and its American Stroke Association division ("ASA") have set goals to improve the cardiovascular health of all Americans by 20 percent and to reduce cardiovascular disease and stroke mortality by 20 percent by 2020. Based on well-documented research that uninsured and under-insured Americans with heart disease and stroke experience higher mortality rates, poorer blood pressure control, greater neurological impairments and longer hospital stays after a stroke, the AHA /ASA worked to represent the needs and interests of heart disease and stroke patients during the congressional debates on healthcare reform, and supported patient-centered provisions of the Affordable Care Act.

SUMMARY OF ARGUMENT

All Americans use or will use health care services, and the lifetime risks for every American of acquiring one of the diseases or conditions towards which *amici* direct their efforts are very high. Moreover, the costs of treating such serious conditions can often also be very high, and are generally beyond the financial means of individuals or families. The question is thus not whether individual Americans will incur health care expenses, but how they will be financed. How these purchases are financed, in turn, has substantial economic effects on interstate commerce

because of the distinguishing characteristics of health care and the unique cost-shifting that occurs in the health care market as a result. Access to health insurance also greatly improves access to health care, and the consequent outcomes for patients with chronic diseases and conditions.

Two central provisions of the Affordable Care Act's regulatory scheme—the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status in the determination of insurance premium rates—are absolutely critical to assuring that patients with chronic diseases and conditions have access to insurance, and hence to quality care. These key provisions were made a part of the Act in response to failures in the health insurance market that left individuals, especially those affected by serious and chronic conditions such as cancer, diabetes, heart disease, and stroke, without insurance and facing burdensome costs and poorer health outcomes. Congress corrected these failures to achieve its broader regulatory goals of protecting patients and reducing costs by improving the availability, affordability, and quality of health insurance. These provisions cannot be effective and successful, however, without the minimum coverage provision.

ARGUMENT

I. THE "ACTIVITY-INACTIVITY" DISTINCTION IS NOT A PRACTICAL WAY TO THINK ABOUT HEALTH INSURANCE AND HEALTH CARE MARKETS

Under the Commerce Clause, Congress may regulate, among other things, "activities that substantially affect interstate commerce." *Gonzalez v. Raich*, 545 U.S. 1, 16-17 (2005) (citations omitted). The

primary argument that the minimum coverage provision falls outside Congress' broad Commerce Clause powers – which indisputably include the power to regulate insurance, *see United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944) – is that this Court's references to "activities" that affect interstate commerce are intended to mean that "inactivity" cannot be regulated. See *Florida v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1351 n. 14 (11th Cir. 2011) (Marcus, J., dissenting) (noting "the central foundation – the dichotomy between activity and inactivity – on which the plaintiffs and the district court rely for their position that upholding the individual mandate would convert the Commerce Clause into an unlimited general police power.").

The "activity-inactivity" paradigm has no precedent in the decisions of this Court. *See Seven-Sky v. Holder*, No. 11-5047, slip op. at 29 -30 (D.C. Cir. Nov. 8, 2011) ("No Supreme Court case has ever held or implied that Congress's Commerce Clause authority is limited to individuals who are presently engaging in an *activity* involving, or substantially affecting, interstate commerce. . . . To be sure, a number of the Supreme Court's Commerce Clause cases have used the word "activity" to describe behavior that was either regarded as within or without Congress's authority. But those cases did not purport to limit Congress to reach only *existing* activities."). It also overlooks the unique characteristics of the health care market and the substantial effect of uninsured individuals on the interstate health care and health insurance markets. How individuals finance health care purchases substantially affects interstate commerce, regardless of whether they purchase health insurance, pay out-of-pocket, or rely on government

or private funding. The circuit court's decision also neglects to account for the significant differences between health care and other goods.

A. Health Care Is Different From Other Consumer Goods And Services

Health care is unlike any other consumer good or service because we often can literally not live without it. For example, bus rides, carpools and walking can substitute for cars, and a workout DVD for a gym club membership, but there is often no substitute for health care procedures performed by professionals, especially when they are needed most. Additionally, decisions about whether, when, and how to pay for transportation, gym club memberships, and other consumer goods or services do not shift direct costs to third parties. Moreover, consumers cannot opt out of the health care market or decide not to purchase health care because the need for health care is not only difficult to predict, but also practically inevitable at some point in life. Looking just at the diseases that are the focus of this *amicus curiae* brief, alone:

— One out of two men and one out of three women will develop some form of cancer in his or her lifetime, even if certain skin cancers and early-stage tumors are excluded. AMERICAN CANCER SOCIETY, CANCER STATISTICS 2010 SLIDE PRESENTATION 19-20 (2010), http://www.cancer.org/Research/CancerFacts Figures/.

— Currently, an estimated 25.8 million Americans have diabetes, CENTER FOR DISEASE CONTROL AND PREVENTION, NATIONAL DIABETES FACT SHEET 2011 2 (2011), http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf., and if present trends continue, one in three Americans and nearly one in two African

Americans and Hispanics born in 2000 will develop diabetes in their lifetime. K. M. Venkat Narayan, et al., *Lifetime Risk for Diabetes Mellitus in the United States*, 290 J. AM. MED. ASS'N. 1884, 1888 (2003).

— By 2050, as many as one in three adult Americans are expected to have diabetes. James P. Boyle, et al., *Projection of the year 2050 burden of diabetes in the US adult population: dynamic modeling of incidence, mortality, and prediabetes prevalence*, POPULATION HEALTH METRICS, Oct. 22, 2010 at 4.

— An estimated 82.6 million American adults (more than one in three) have one or more types of cardiovascular disease. Veronique L. Roger, et al., *Heart Disease and Stroke Statistics 2011 Update: A Report From the American Heart Association* 187 (2010), *available at* http://circ.ahajournals.org/cgi/reprint/CIR.0b013e3182009701v1/.

— The lifetime risk for developing cardiovascular disease among those starting free of known disease is two in three for men and greater than one in two for women. *Id.* at 31.

These statistics in combination demonstrate the strong likelihood that, even focusing only on this group of chronic diseases, most people will at some point need health care and participate in the health care market. Without a better and more equitably organized health insurance market, the current barriers to care are unlikely to be overcome, and individuals and their families will continue to bear the burden of substantial costs and worse health outcomes.

Aside from the lack of a substitute for health care and the inevitable need for it, health care is also different from other consumer goods and services because we as a people place it in a different category. Unlike most other goods and services, a person's health, well-being, and chance for positive health outcomes when sick are generally not considered to be best left wholly dependent on that person's ability to pay for health care. For example, we abhor reports of patients diagnosed with cancer who are unable to afford potentially life-saving chemotherapy treatment and are left helpless as their condition worsens. We find it tragic when people with diabetes delay treatment or fail to take needed medications for so long because of the high costs that they are forced to amputate a limb. We are frustrated by the all too common occurrence of people with cardiovascular disease cutting pills and forgoing treatment because they cannot afford to refill their prescriptions or visit a doctor.

These natural, indeed nearly universal, human responses are why the *amici* have drawn hundreds of thousands of members and millions of volunteers and donors to help increase access to quality care for those with debilitating or life-threatening diseases. A person who wants a car he or she cannot afford is unlikely to spark a similar reaction. As organizations dedicated to addressing the devastating impact of these diseases, we know that life-saving treatments are fundamentally different than the desire to own an automobile or other consumer goods.

B. As A Result Of The Unique Characteristics Of Health Care, The Market For Health Care Involves Significant Cost-Shifting That Has Substantial Economic Effects, Regardless Of Whether Decisions About Financing Health Care Are Characterized As An Activity Or Inactivity

Because of the unique characteristics of health care, Congress has required health care providers in certain instances to provide health care regardless of a patient's ability to pay. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd. The requirement to provide health care in certain instances, regardless of a patient's ability to pay, coupled with the high cost of health care, often results in the costs to provide care for uninsured and underinsured individuals being shifted to insured patients or government health programs. To provide uncompensated care for uninsured and underinsured patients, health care providers pass the costs onto other participants in the health insurance market, driving up insurance premiums, *see* Patient Protection and Affordable Care Act § 1501(a), and, thus, exacerbating problems of higher costs and worse health outcomes caused by the lack of affordable, quality health insurance. This cost-shifting is unique to the market for health care because, unlike an individual's decision not to buy a car or other consumer goods, third parties often bear the costs of an individual's decision to not buy health insurance. Costs to provide care for the uninsured and underinsured are also shifted to third parties even when individuals are not uninsured or underinsured by choice. For example, prior to the Affordable Care Act's ban on pre-existing condition exclusions and the prohibition of discrimination based on health status in deter-

mining insurance premium rates, cancer, diabetes, heart disease, and stroke patients and survivors who wanted and needed health insurance were often unable to obtain health insurance because they were denied coverage or could not find affordable and adequate health insurance to cover the care they needed to manage their chronic diseases.

Congress found that the cost of providing uncompensated care to the uninsured was $43 billion in 2008. *See id.* § 10106(a). Based on the unique characteristics of the health care market, this cost must be shifted to other market participants. Congress also found that cost-shifting from providing uncompensated care resulted in increases to insurance premiums for families by over $1,000 a year on average. *Id.* Moreover, this cost-shifting is neither transparent nor equitable. Regardless of whether an individual's decision about how to finance health care can be characterized as an "activity" or "inactivity," this unique cost-shifting that occurs in the market for health care has substantial economic effects that impact interstate commerce. *See Seven Sky v. Holder*, slip op at 33 ("It suffices for this case to recognize, as noted earlier, that the health insurance market is a rather unique one, both because virtually everyone will enter or affect it, and because the uninsured inflict a disproportionate harm on the rest of the market as a result of their later consumption of health care services.")

II. THE MINIMUM COVERAGE PROVISION IS NECESSARY AND PROPER TO IMPLEMENT THE AFFORDABLE CARE ACT'S BROADER REGULATORY SCHEME.

As noted above, Congress indisputably has the authority under the Commerce Clause to regulate interstate insurance markets. Congress also has the authority under the Necessary and Proper Clause, U.S. Const. art. I, §8, cl. 18, to use a "means that is rationally related to the implementation of a constitutionally enumerated power." *United States v. Comstock,* 130 S. Ct. 1949, 1956 (2010).

No party or court has contended that the two features of the Affordable Care Act of particular importance to *amici*—the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status in determining insurance premium rates—were not properly enacted pursuant to Congress's Commerce Clause authority to regulate the interstate health insurance market. Indeed, the Eleventh Circuit expressly declined to invalidate these provisions. *See Florida v. HHS*, 648 F.2d at 1328 ("The individual mandate, however, can be severed from the remainder of the Act's myriad reforms . . . The Act's other provisions remain legally operative after the mandate's excision.") These two features are critically important to the Affordable Care Act's regulatory scheme intended to provide protections to patients and reduce costs by improving the availability, affordability, and quality of health insurance.

The government has acknowledged, however, that these two provisions cannot be implemented workably without the minimum coverage provision. *See* p. 6, *supra*. For that reason, the minimum coverage

provision is not only rationally related to Congress's exercise of its authority to regulate the interstate health insurance market, it is essential to the success of Congress's broader regulatory scheme.

A. The Affordable Care Act Addresses Failures Of The Interstate Health Insurance Market That Hurt Patients And Contribute To The High Cost Of Health Insurance And Health Care

The debate over health care reform and Congress's enactment of the Affordable Care Act were spurred by the failures and high costs of the interstate health insurance and health care markets. These failures hurt not only the nation's economic well-being, but also the health and well-being of individual Americans. One of the failures of the health insurance market that led to the nation's healthcare crisis involved the insurance industry's severe medical underwriting practices that often left those most in need of care without adequate health insurance. Reforming the health insurance industry to protect patients against such discriminatory practices was a primary focus of the *amici* and of Congress.

1. The Act addresses the problem of cancer, diabetes, heart disease, and stroke patients and survivors who want and need health insurance but often cannot obtain it

The cost of services to treat cancer, diabetes, heart disease, and stroke can be beyond the reach of all but the wealthiest individuals absent some form of insurance. These chronic conditions have significant financial implications for cancer, diabetes, heart disease, and stroke patients and survivors as well as

their families. The costs for necessary health care can be so high that even insured patients can face very significant expenses. For example, 5 percent of even privately insured breast cancer patients had total out-of-pocket costs that exceeded $31,264. Karyn Schwartz et al., *Spending to Survive: Cancer Patients Confront Holes in Health Insurance System* (Kaiser Family Foundation and the American Cancer Society) (2009) *available at* http://www.kff.org/insurance/upload/7851.pdf. The high cost of treating cardiovascular disease is also a leading cause of medical bankruptcy. David U. Himmelstein, et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741 (2009). Among families with high levels of medical debt resulting in bankruptcy, those with stroke had average out-of-pocket medical costs of $23,380 and those with heart disease had average medical costs of $21,955. *Id.* at 745.

To be better able to handle the high costs associated with cancer, diabetes, heart disease, and stroke, patients and survivors, on their own initiative, want and need health insurance. However, cancer, diabetes, heart disease, and stroke patients and survivors have often been unable to obtain health insurance or find an adequate, affordable health insurance plan to cover their medical needs. Without the Affordable Care Act's provisions banning pre-existing condition exclusions and prohibiting discrimination based on health status in the determination of health insurance rates, cancer, diabetes, heart disease, and stroke patients and survivors often reported being denied health insurance or offered health insurance only with significantly higher insurance premiums, despite their efforts to obtain health insurance. For example, a prostate

cancer survivor who has been cancer-free for over ten years voiced his frustration to the ACS over insurers refusing him health insurance, saying "after cancer you may as well kiss your way of life and your family's way of life goodbye, because no one wants to talk to you about getting comprehensive, affordable coverage." Karyn Schwartz et al., *Spending to Survive: Cancer Patients Confront Holes in Health Insurance System* 17 (Kaiser Family Foundation and the American Cancer Society) (2009) *available at* http://www.kff.org/insurance/upload/7851.pdf.

The problem is not merely anecdotal. One of every three people diagnosed with cancer under age 65 are uninsured or have been uninsured at some point since diagnosis. AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, *A National Poll: Facing Cancer in the Health Care System* (2010) *available at* http://www.ascan.org/healthcare/cancerpoll. Of the cancer patients who reported being uninsured, 75 percent attributed their lack of health insurance to affordability or pre-existing condition exclusions. *Id.*

Similarly, approximately 6.5 million (or 15 percent) of adults who report having cardiovascular disease are uninsured, and more than half of the uninsured with cardiovascular disease cite cost as the reason they lack coverage. Raymond J. Gibbon, et al., *The American Heart Association's 2008 Statement of Principles for Healthcare Reform*, 118 J. AM. HEART ASS'N. 2209 (2008). Additionally, between 10 percent and 22 percent of adults with congenital heart disease are uninsured, and 67 percent have reported difficulty in obtaining health insurance or changing jobs to guarantee coverage. David J. Skorton, et al., *Task Force 5: adults with congenital heart disease: access to care,* 37 J. AM. C. CARDIOLOGY 1193, 1195 (2001). Many

individuals with diabetes also report being unable to obtain any individual health insurance because of their diabetes, or being offered policies which are significantly more expensive than those for people without diabetes. Karen Pollitz et al., *Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes* 9-12 (Georgetown University Health Policy Institute and the American Diabetes Association) (2005) *available at* http://www.healthinsuranceinfo.net/diabetes_and_health_insurance.pdf. The recent recession has only magnified problems for cancer, diabetes, heart disease, and stroke patients and survivors because employer-sponsored insurance covers more than half of all people under age 65, and the rise of unemployment put many individuals' health insurance at risk. *See* Karyn Schwartz, et al., *Patients Under Pressure: Profiles of How Families Affected by Cancer Are Faring in the Recession* 1 (Kaiser Family Foundation and the American Cancer Society) (2009) *available at* http://www/kff.org/insurance/7934.pdf.

There is also a tremendous problem with individuals being underinsured. Nearly one in three (or 28.8 percent) of cancer patients who are insured have an out-of-pocket health care burden that exceeds 10 percent of their family income. Jessica S. Banthin & Didem M. Bernard, *Changes In Financial Burdens for Healthcare: National Estimates for the Population Younger Than 65 Years,* 296 J. AM. MED. ASS'N. 2712, 2717 (2006). More than one in nine cancer patients with insurance have out-of-pocket health care burdens exceeding 20 percent of their family income in health care expenditures. *Id*. More than a third (39.1 percent) of households that include an individual with diabetes have health care costs totaling 10 percent or more of household income, while 18

percent of such households have costs totaling 20 percent or more of household income. *Id.* This high cost to the underinsured has led to numerous bankruptcies due to medical expenses. *See* David U. Himmelstein, et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, Health Affairs, Feb. 2, 2005 at 69.

To address the problem of underinsurance, the Affordable Care Act includes several provisions that, in combination with the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status, improve the availability, affordability, and quality of health insurance and health care. These include a framework for an essential benefits package and the elimination of lifetime and annual limits. *Are Mini-Med Policies Really Health Insurance*: *Hearing Before the S. Comm. on Commerce, Sci. and Transp.*, 111th Cong. 2d Sess. S. Hrg. 111-1087, 5-6 (Dec. 1, 2010) (statement of Stephen Finan, American Cancer Society Cancer Action Network). Additionally, the Act offers subsidies to assist individuals and families below 400 percent of the federal poverty level and requires limits on out-of-pocket expenses in all insurance plans, except those that are grandfathered. *Id.*

2. Without adequate health insurance, people have poorer health outcomes and require more costly health care

The lack of adequate and affordable health insurance has serious consequences for cancer, diabetes, heart disease, and stroke patients and survivors. Individuals without health insurance are less likely to receive preventative treatment or early detection screenings and are more likely to delay treatment.

For example, in a 2010 ACS poll of individuals under age 65 who have cancer or a history of cancer, 34 percent reported delaying care because of cost in the past 12 months. AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, *A National Poll: Facing Cancer in the Health Care System* (2010). More specifically, 29 percent delayed needed health care, 19 percent delayed getting a recommended cancer test or treatment, and 22 percent delayed a routine cancer check-up. *Id.* At every level of education, individuals with health insurance are about twice as likely as those without it to have access to key cancer early detection procedures, such as mammography or colorectal screenings. Elizabeth Ward, et al., *Association of Insurance with Cancer Care Utilization and Outcomes*, 58 CANCER J. FOR CLINICIANS 9 (2008).

With respect to heart disease, an AHA survey found that more than half of the cardiovascular patients responding reported difficulty paying for medical care. Of those reporting difficulty paying for medical care, 46 percent said they had delayed getting needed medical care, 43 percent had not filled a prescription, and 31 percent had delayed a screening test. Synovate, *Advocacy Survey Among CVD & Stroke Patients* 23 (American Heart Association) (2010) *available at* http://americanheart.org/presenter.jhtml?identifier=3072496. Even during a heart attack, studies show that uninsured patients are more likely to delay seeking medical care. Kim G. Smolderen, et al., *Health Care Insurance, Financial Concerns in Accessing Care, and Delays to Hospital Presentation in Acute Myocardial Infarction*, 303 J. AM. MED. ASS'N. 1392, 1395-99 (2010).

The same patterns occur among uninsured individuals with diabetes. For example, among persons aged 18 to 64 with diabetes mellitus, those who had no health insurance during the preceding year were six times as likely to forgo needed medical care as those who were continuously insured. JB Fox, et al., *Vital Signs: Health Insurance Coverage and Health Care Utilization—United States, 2006-2009 and January-March 2010,* 59 MORBIDITY AND MORTALITY WKLY. REP. 1448, (2010). Lack of health insurance also leads to cases of diabetes going undiagnosed, delaying the start of needed treatment and increasing the risks of complications. Among those with diabetes, 42.2 percent of those without health insurance were undiagnosed, compared with 25.9 percent for those with insurance. Xuanping Zhang, et al., *The Missed Patient with Diabetes: How Access to Health Care Affects the Detection of Diabetes*, 31 DIABETES CARE 1748, 1749 (2008).

As a result of lack of preventative care and delayed treatment, uninsured patients have poorer outcomes and require more costly long-term and invasive treatment than individuals with insurance. For example, in a multivariate analysis including sex, age, type of treatment facility, location of residence, median household income in zip code of residence, and education level, health insurance status was the strongest predictor of oropharyngeal cancer and tumor size at diagnosis, with uninsured patients having the greatest likelihood of advanced disease stage at diagnosis. Amy Y. Chen et al., *The Impact of Health Insurance Status on Stage at Diagnosis of Oropharyngeal Cancer,* 110 CANCER 395, 400-01 (2007). Similarly, patients who are uninsured have substantially elevated risks of being diagnosed with advanced stage breast cancer compared with

privately insured patients. Michael T. Halpern, et al., *Insurance Status and Stage of Cancer at Diagnosis Among Women with Breast Cancer*, 110 CANCER 403, 409 (2007). Cancer patients diagnosed at an advanced stage experience lower survival, more debilitating, invasive treatment, and greater long-term treatment-related morbidity. *Id.* at 408.

Likewise, uninsured patients with cardiovascular disease experience higher mortality rates and poorer blood pressure control than their insured counterparts. Jay J. Shen & Elmer L. Washington, *Disparities in outcomes among patients with stroke associated with insurance status*, 38 STROKE 1010, 1013 (2007); J. Michael McWilliams, et al., *Health insurance coverage and mortality among the near-elderly*, 23 HEALTH AFFAIRS 223, 229 (2004); O. Kenrik Duru, et al., *Health insurance status and hypertension monitoring and control in the United States*, 20 AM. J. HYPERTENSION 348 (2007). Those who suffer a stroke who are uninsured experience greater neurological impairments, longer hospital stays and up to a 56 percent higher risk of death than the insured. Shen, *supra*, at 1013. Patients with no health insurance were also twice as likely to have a diabetic complication as patients who had insurance. Nina E. Flavin, et al., *Health Insurance and the Development of Diabetic Complications,* 102 SO. MED. J. 805 (2009).

In sum, there can be no doubt that Congress acted to address serious shortcomings in the health insurance market.

B. The Minimum Coverage Provision Is Essential To The Implementation Of Two Key Provisions Of The Act That Correct The Failures Of The Interstate Health Insurance Market And Improve The Availability, Affordability, And Quality Of Health Insurance

To address the failures of the health insurance market and the tragic consequences they have for individuals, especially cancer, diabetes, heart disease, and stroke patients and survivors, Congress enacted the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status. The ban on pre-existing condition exclusions ensures that all individuals are able to participate in the health insurance market and protects individuals from being forced out of the market based on risk. The prohibition of discrimination based on health status similarly protects patients from being priced out of the health insurance market based on risk.

By ensuring that health insurance is available to all individuals regardless of prior history, the Affordable Care Act protects patients with chronic conditions from the negative health and financial outcomes that accompany being uninsured or underinsured. However, the effective implementation of these provisions is critical; otherwise cancer, diabetes, heart disease, and stroke patients and survivors will continue to be plagued by the serious financial and health consequences associated with the lack of adequate health insurance.

Congress recognized that the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status must be coupled with the minimum coverage provision to be effective in achieving the patient protections, cost reductions, elimination of inequitable cost shifting, and improvements to health insurance Congress intended. Affordable Care Act, § 10106(a). Congress explained that "if there were no [minimum coverage provision], many individuals would wait to purchase health insurance until they needed care" because the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status guarantee that individuals will be issued health insurance regardless of their health history or status. *Id.*

The adverse selection that would result from the decoupling of the ban on pre-existing condition exclusions and the prohibition of discrimination based on health status from the minimum coverage provision could ultimately collapse the health insurance industry. Insurance pools would be populated by individuals who are ill and thus drive the cost of coverage to unsustainable levels creating a death spiral in the industry as fewer and fewer healthy people choose (or are able) to buy very expensive coverage before they actually become ill. The Affordable Care Act's two central provisions thus must be combined with the minimum coverage provision to mitigate the problematic cost-shifting that occurs in the health care market and ensure that everyone shares in the financing of health care. Only through the minimum coverage provision will adverse selection be minimized, and costs spread more broadly across current and potential participants in the health care market to reduce the cost of health insurance overall, thus

enabling achievement of the goals of Congress's broader regulatory scheme.

The minimum coverage provision is also essential to the effective implementation of the pre-existing condition exclusion ban and the elimination of discrimination based on health status because it allows the health insurance market to be restructured around competition based on price, quality, and value, instead of the risk segmentation that prevailed prior to the enactment of the Affordable Care Act. For these reasons, the minimum coverage provision is not just "necessary and proper" for the execution of the Affordable Care Act's ban on pre-existing condition exclusions and the prohibition of discrimination based on health status, but is absolutely essential to their successful implementation.

CONCLUSION

Amici respectfully submit that the court of appeals' decision invalidating the individual responsibility provision of the Act should be reversed.

Respectfully submitted,

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