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## Examining the Evidentiary Basis of Congress's Commerce Clause Power To Address Individuals' Health Insurance Status



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### Introduction

**C**hief among the issues that the U.S. Supreme Court will consider in *HHS v. Florida* is the question<sup>1</sup> of whether Congress has the constitutional power to

<sup>1</sup> No. 11-398; petition on Question 1 (Did Congress have the power under Article I of the Constitution to enact the minimum coverage provision of the Patient Protection and Affordable Care Act? (2) Is the suit brought by respondents to challenge the minimum coverage provision of the Patient Protection and Affordable Care Act barred by the Anti-Injunction Act, 26 U.S.C. § 7421(a)?) granted Nov. 14, 2011, <http://www.supremecourt.gov/qp/11-00398qp.pdf>. For a full listing of

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apply a “minimum essential coverage requirement”<sup>2</sup> on most nonelderly Americans. Opponents of the Patient Protection and Affordable Care Act (the Affordable Care Act or the Act) provision (referred to as the “Individual Responsibility” requirement) argue that compelling individuals to buy affordable health insurance coverage exceeds congressional powers. By contrast, the Department of Justice and supporters of the law assert that the minimum coverage requirement is consistent with a long line of Supreme Court decisions regarding the power of Congress to regulate individual conduct.<sup>3</sup> The Obama administration, in a brief filed on Jan. 9, argues that congressional authority to act can be found under both its taxing powers as well as its power under the commerce clause and necessary and proper clause to regulate interstate commerce. The commerce clause arguments are of special interest, because it is this basis of power that has received so much attention in the lower court decisions to date.

How the court resolves the question of whether Congress's commerce clause powers support the minimum essential coverage requirement will depend on how it applies legal precedent to a law that is widely viewed as unique.<sup>4</sup> But before reaching the question of whether

all actions in the case since certiorari was granted see <http://www.supremecourt.gov/Search.aspx?FileName=/docketfiles/11-398.htm>.

<sup>2</sup> PPACA § 1501(b) adding § 5000A to subtitle D of the Internal Revenue Code of 1986.

<sup>3</sup> See, e.g., Brief of the United States on Question One in *HHS v. Florida*, (Jan. 9, 2012). [http://www.americanbar.org/content/dam/aba/publications/supreme\\_court\\_preview/briefs/11-398\\_petitioner.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs/11-398_petitioner.authcheckdam.pdf).

<sup>4</sup> See, e.g., *Thomas More Law Center v. Obama*, 651 F.3d 529 at 558-559 (Sutton J. concurring) citing CBO Memorandum, The Budgetary Treatment of an Individual Mandate to

the solution is constitutional, the court first must decide whether the conduct that the Act regulates (i.e., individuals' health insurance status) is a matter that affects commerce.<sup>5</sup>

This article focuses on this threshold question of how to characterize or describe the problem that Congress has sought to address through the enactment of law in relation to its constitutional powers, in this case, its powers under the commerce clause. Following a brief overview of the scope of congressional power under the commerce clause, whose reach is considered central to this case, we turn to the minimum essential coverage provision and the congressional findings on which it rests. The article then presents evidence from the health services research literature that shows the extent to which being uninsured affects the broader economy. The article next examines how the various Courts of Appeal that have ruled to date have addressed this task of problem definition. It concludes with a discussion of the broader implications for health policy of how the court ultimately defines the problem of being uninsured.

### The Scope of Congress's Commerce Clause Powers

The Supreme Court has recognized three broad areas in which Congress can lawfully regulate under the commerce clause:<sup>6</sup> (1) the use of the channels of interstate commerce; (2) the instrumentalities of interstate commerce or persons or things in interstate commerce; and (3) those activities having a substantial relation to interstate commerce . . . i.e., those activities that substantially affect interstate commerce.<sup>7</sup> The three federal appeals courts that reached the merits (the U.S. Court of Appeals for the Eleventh Circuit, whose decision to strike down the minimum essential coverage requirement is the one that the court will review,<sup>8</sup> and the Courts of Appeal for the Sixth and D.C. Circuits, which upheld its constitutionality<sup>9</sup>) focused on the third area in the trilogy, namely, whether being uninsured amounts to an activity that substantially affects interstate commerce.

Under Supreme Court precedent, two types of individual activities might be said to substantially affect interstate commerce. First, individual activity, even if purely local and intrastate, can, when aggregated, have an impact on commerce. For example, in perhaps the most foundational precedent in this case, *Wickard v. Filburn*,<sup>10</sup> the court held that the decision by a single wheat farmer to fend for his family by growing his own supply rather than entering the commercial market for wheat had a substantial impact on commerce and thus

was subject to government regulation; while one farmer's actions, standing alone, might have been insubstantial, the aggregated effects were other wheat farmers to make the same decision would have been quite substantial. Furthermore, the court has ruled that Congress can reach individual conduct that is purely intrastate and noneconomic in nature when its regulation is part of a broader regulatory scheme to address an overarching national problem affecting commerce and the economy.<sup>11</sup>

### The Minimum Essential Coverage Requirement: Congressional Findings

The minimum essential coverage requirement is designed to assure that most U.S. taxpayers who can afford to do so acquire insurance coverage.<sup>12</sup> To effectuate this goal, the Act adds an "individual responsibility" requirement to the Internal Revenue Code; this requirement provides that most taxpayers with incomes above the federal filing threshold<sup>13</sup> must show evidence of "minimum essential coverage," as defined under the Act.<sup>14</sup> Taxpayers who do not provide such evidence must pay a penalty pegged to the national average price of a "bronze" level insurance policy,<sup>15</sup> subject to an annual upper limit.<sup>16</sup> This requirement is accompanied by comprehensive market reforms to prevent discrimination against the sick,<sup>17</sup> refundable tax credits and cost sharing assistance to make coverage more affordable,<sup>18</sup> and the establishment of state health insurance Exchanges through which health insurance can be purchased;<sup>19</sup> collectively, these provisions aim to make insurance both affordable and available. The Act's insurance reforms are accompanied by a wide-ranging restructuring of numerous existing laws in order to strengthen public insurance, expand coverage to the poorest Americans, and address deeper problems of health care quality, cost, and efficiency through performance improvement initiatives and public health investments.<sup>20</sup>

The Act's congressional findings clarify that where the minimum essential coverage requirement is concerned, congressional intent was to address a problem of national economic importance: the fundamental mismatch between the country's approach to financing health care on one hand and Americans' need for and use of health care on the other. This mismatch is the result of three basic factors, all of which are addressed under the Act: (1) a limited and weakening employer-

<sup>11</sup> *Gonzalez v. Raich* 545 U.S. 1 at 25 (2005).

<sup>12</sup> The Act contains certain exemptions and exceptions, including a religious exemption and a hardship exemption. The requirement does not reach persons not lawfully present in the United States or individuals who are incarcerated, 26 U.S.C. § 5000A(d) and (e) added by PPACA § 1501.

<sup>13</sup> 26 U.S.C. § 5000A(e)(2) added by PPACA § 1501.

<sup>14</sup> 26 U.S.C. § 5000A(f), added by PPACA § 1501.

<sup>15</sup> 26 U.S.C. § 5000A(c)(1), added by PPACA § 1501.

<sup>16</sup> 26 U.S.C. § 5000A(c)(2), added by PPACA § 1501.

<sup>17</sup> See, e.g., §§ 2701 (fair health insurance premiums), 2704 (prohibiting pre-existing condition exclusions), 2703 (guaranteed availability of coverage) and 2704 (guaranteed renewability of coverage), added by PPACA § 1201.

<sup>18</sup> PPACA § 1401 adding 26 U.S.C. § 36B, advance refundable tax credits and PPACA § 1402, related to cost-sharing reductions.

<sup>19</sup> PPACA § 1311.

<sup>20</sup> PPACA Titles II through VI.

Buy Health Insurance at 1 (August, 1994) and Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis* at 8-9 (Oct. 15, 2010).

<sup>5</sup> *Marbury v. Madison*, 1 Cranch 37, 2 L. Ed. 60 (1803); *United States v. Morrison*, 529 U.S. 598, 605 (2000).

<sup>6</sup> U.S. Constitution, Art. 1 § 8.

<sup>7</sup> *United States v. Lopez*, 514 U.S. 549 at 558-559 (1995).

<sup>8</sup> *Florida v. HHS*, 648 F.3d 1235 (11th Cir. 2011). <http://www.healthreformgps.org/wp-content/uploads/ruling.pdf>

<sup>9</sup> *Thomas More Law Center v. Obama*, 651 F.3d 529 (6th Cir. 2011) <http://www.healthreformgps.org/wp-content/uploads/ACA-6th-circuit-062911.pdf> and *Seven-Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011) <http://www.healthreformgps.org/wp-content/uploads/DC-Court-of-Appeals-Ruling.pdf>.

<sup>10</sup> 317 U.S. 111 (1942).

sponsored coverage market; (2) a dysfunctional individual insurance market that cannot operate as a viable alternative for working-age individuals and families without access to employer coverage; and (3) the absence of sufficient public insurance coverage for the most impoverished nonelderly persons.<sup>21</sup>

The Congressional findings begin with the assertion that “the individual responsibility requirement . . . is commercial and economic in nature, and substantially affects interstate commerce . . .”<sup>22</sup> Supreme Court precedent makes clear that congressional assertions of a nexus between a problem and interstate commerce alone are insufficient to uphold the constitutionality of a law.<sup>23</sup> In this case, however, the findings point to certain evidence of this basic misalignment, which by now should be familiar to most students of health policy: *first*, the fact that in the absence of a coverage requirement, some individuals “make an economic and financial decision to forego health insurance and attempt to self-insure,”<sup>24</sup> thereby increasing financial risks to both “households and medical providers”;<sup>25</sup> *second*, the fact that private health insurance finances approximately one-third of the health care that is consumed;<sup>26</sup> *third*, the fact that the uninsured are in poorer health and cost the national economy more than \$200 billion annually as a result of poorer health and shorter lifespans;<sup>27</sup> and *fourth*, the fact that when they are sick, the uninsured receive health care nonetheless, thereby shifting tens of billions of dollars in uncompensated care costs (\$43 billion in 2008 alone) onto persons with public and private health insurance, leading to an increase in family premiums “on average over \$1,000 a year.”<sup>28</sup> These findings are in addition to other congressional findings contained in the Act that establish a nexus between interstate commerce and regulation of the private insurance market. But the nexus between the insurance industry and commerce has been explicitly recognized by the court for decades<sup>29</sup> and thus does not raise the same “first impression” issue that arises in the case of the minimum essential coverage requirement.

## The Evidence Base for the Affordable Care Act’s Congressional Findings

The congressional findings regarding the relationship between the ACA coverage requirement and interstate commerce rest on a wealth of evidence demonstrating the fractured nature of the relationship between health care financing and the use of care, a phenomenon most clearly illustrated by the large vol-

ume of hospitalization care (more than 2.1 million separate cases of hospitalization) furnished to uninsured patients annually.<sup>30</sup> Evidence amassed and analyzed by health services researchers sheds considerable light on the economic spillover effects of being uninsured, not only on individuals and their families, but more importantly in the context of the minimum essential coverage requirement, on community and regional health care systems and the economy as a whole.

## Economic Spillover Effects of Being Uninsured

Perhaps the most exhaustive review of the subject was published by the Institute of Medicine over the 2001-2003 time period, which detailed the health, health care, and economic spillover aspects of being uninsured.<sup>31</sup> The IOM findings underscore the fact that although it is associated with delayed and inappropriate care,<sup>32</sup> being uninsured does not keep people out of the health care system in times of emergency or urgent need.<sup>33</sup> Like the wheat farmer in *Wickard*, who tried to remove himself from the commercial market, people who go without health insurance nonetheless affect commerce when, because of their unanticipated, urgent, and costly need for health care, they use services but risk the inability to pay for care at the point of service.

In this regard, the IOM found enormous spillover effects. Specifically, the IOM concluded from its research that communities whose residents experienced elevated levels of being without health insurance also had fewer beds per capita, fewer specialized services for conditions such as psychiatric and alcohol dependence and AIDS, fewer intensive care beds, weaker burn and shock trauma care, and lower financial margins.<sup>34</sup> The IOM findings underscore the aggregated economic effects of uninsurance across communities and regions. In its report, the IOM pictorialized the “cascade of effects”<sup>35</sup> that are both “causal and temporal”<sup>36</sup> and that flow from the lack of health insurance at the individual level, as represented in **Figure 1**.

<sup>30</sup> U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Research Brief: The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills (2008).

<sup>31</sup> Institute of Medicine, *Coverage Matters: Insurance and Health Care* (National Academy Press, 2001); Institute of Medicine, *Care Without Coverage: Too Little; Too Late* (National Academy Press, 2002); Institute of Medicine, *Health Insurance is a Family Matter* (National Academy Press, 2002); Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (National Academy Press, 2003).

<sup>32</sup> Institute of Medicine, *Care Without Coverage*, op. cit. Ch. 3.

<sup>33</sup> Institute of Medicine, *Coverage Matters*, op. cit. Ch. 1.

<sup>34</sup> Institute of Medicine, *A Shared Destiny*, op. cit. Chs. 3 and 4.

<sup>35</sup> IOM, *Care without Coverage*, op. cit. p. 105.

<sup>36</sup> IOM, *Care without Coverage*, op. cit. p. 106.

<sup>21</sup> See generally, Kaiser Family Foundation, *Health Insurance: A Primer* (2011).

<sup>22</sup> PPACA § 1501(a)(1).

<sup>23</sup> *Id.* at 614.

<sup>24</sup> PPACA § 1501(a)(2)(A).

<sup>25</sup> *Id.*

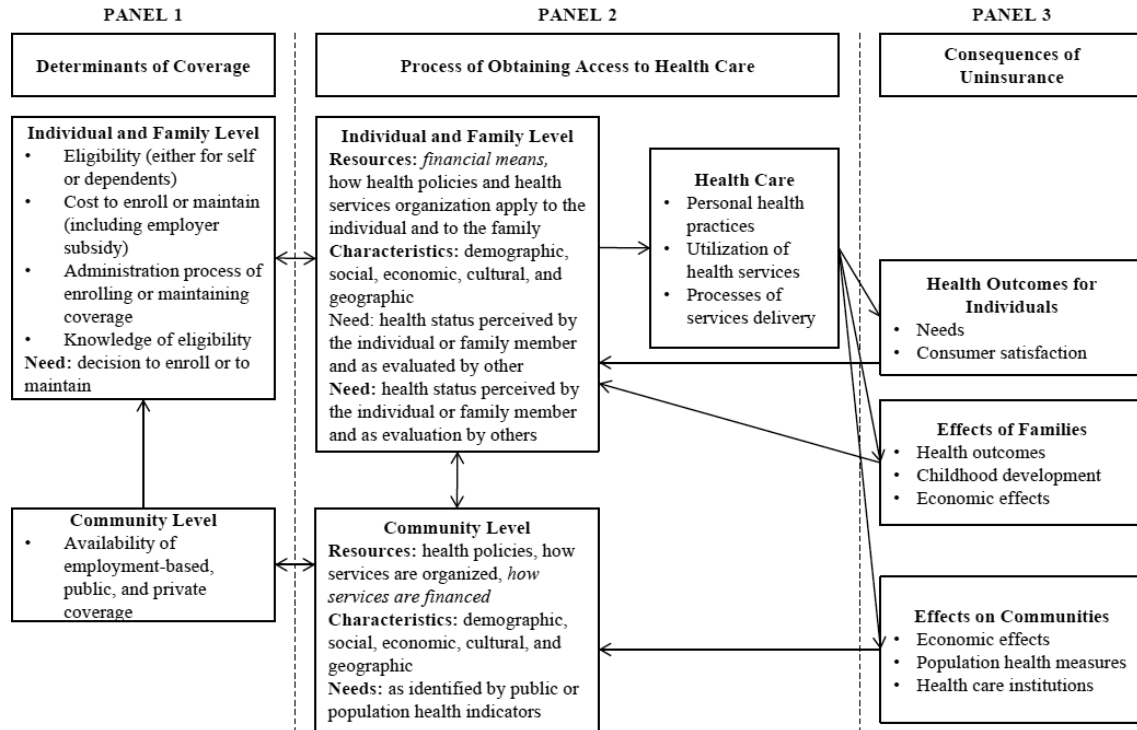
<sup>26</sup> PPACA § 1501(a)(2)(B).

<sup>27</sup> PPACA § 1502(a)(2)(E).

<sup>28</sup> PPACA § 1502(a)(2)(F).

<sup>29</sup> *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944).

**Figure 1. The Impact of Being Uninsured**



A conceptual framework for evaluating the consequences of uninsurance. NOTE: Italics indicate terms that include direct measures of health insurance coverage. Reprinted from *Coverage Matters: Insurance and Health Care* (IOM, 2001a).

If anything, the extent of this spillover impact identified by the IOM is understated. Since 2000, when the IOM began its studies, the proportion of nonelderly adult Americans without health insurance has risen significantly. A decade ago, the figure stood at 14.8 percent; by 2010 it had risen by a full 25 percent, to 18.5 percent of all nonelderly adults. This rise reflects numerous social and economic trends that are relentlessly eroding the voluntary employer-sponsored health insurance scheme that the ACA is designed to bolster and supplement.<sup>37</sup>

This aggregated economic spillover effect flowing from the absence of health insurance is further evident in data drawn from vital statistics and specific population group studies.

### *Births to Uninsured Women*

Data from the nation's vital statistics system indicate that in 2009, virtually all births (99.7 percent) occurred within the health care system,<sup>38</sup> defined as a birth that occurs in a health care setting such as a hospital (or en route to a hospital), free-standing birthing center, clinic, doctor's office, or at home and attended by a clinical

<sup>37</sup> John Holahan and Vicki Chen, *Changes in Health Insurance Coverage in the Great Recession* (Kaiser Commission on Medicaid and the Uninsured, 2011) <http://www.kff.org/uninsured/upload/8264.pdf> (Accessed online Jan. 3, 2012).

<sup>38</sup> Births: Final Data for 2009. National Vital Statistics Reports, Centers for Disease Control and Prevention, Vol. 60, No. 1, November 2011 at 13, [http://www.cdc.gov/nchs/nvss/new\\_births.htm](http://www.cdc.gov/nchs/nvss/new_births.htm).

health care professional.<sup>39</sup> At the same time, estimates drawn from the Medical Expenditure Panel Survey (MEPS)<sup>40</sup> regarding the proportion of births to women who are uninsured at the time of delivery show that during the 2003-2007 time period, approximately 1.1 million pregnant women—approximately one-quarter of all pregnant women—were uninsured during part or all of their pregnancies. The absence of health insurance to pay for an absolutely essential health care need such as pregnancy and newborn care in turn exerts huge pressures on health care systems and public insurance programs, especially Medicaid. The MEPS data project that each year, some 425,000 women (10 percent of all pregnant women per year) will be uninsured in the month of delivery, while 8 percent (nearly 328,000 women) will be uninsured throughout their

<sup>39</sup> *Id.* Based on our analysis of the vital statistics, this estimate in fact may be conservative, since births in which health care use is not specified (i.e., categorized as “other” or “unspecified” in terms of setting or attendant) are classified as occurring outside the health care system.

<sup>40</sup> MEPS is an annual series of surveys conducted by the federal Agency for Healthcare Research and Quality, which surveys a nationally representative sample of non-institutionalized people in U.S. households and collects a variety of data about their insurance status, personal characteristics, health needs, health care utilization, and health care expenditures, based on both surveys of the individuals and of their health care providers. The survey is a widely used source of analytical data about the U.S. health care system, health care utilization, and expenditures.

pregnancies.<sup>41</sup> Women who go through a pregnancy without health insurance—predominantly young adults ages 20-29—comprise two-thirds of those who were uninsured throughout their pregnancies.<sup>42</sup> Lower-income women (family incomes under 200 percent of the federal poverty level)—a group most likely to be aided under health reform—represent 60 percent of the population uninsured throughout pregnancy.<sup>43</sup>

#### *Nonfatal Injuries Involving Use of Hospital Emergency Departments*

A fundamental problem flowing from the mismatch between health care financing and the need for and use of care is the essentially unpredictable nature of need and use. In no case is this unpredictability more in evidence than in the case of hospital emergency care. The Emergency Medical Treatment and Labor Act (EMTALA) obligates all Medicare-participating hospitals with emergency departments to provide screening and stabilization services to persons who come to the hospital emergency department seeking treatment for an emergency medical condition.<sup>44</sup> Data from the Centers for Disease Control and Prevention (CDC) measure the extent of nonfatal injuries—among the most unpredictable of health problems—that are treated in hospital emergency department settings.<sup>45</sup> In 2010, more than 13 percent of American adults ages 20-24 and over 12 percent of those ages 25-29s were treated in a hospital emergency department for a nonfatal injury. Figures hovered at or near 10 percent that year for individuals ages 30 to 44.<sup>46</sup> Furthermore, treatment does not stop at the emergency department. As **Figure 2** shows, with increasing age comes an increasing probability that treatment will continue on to inpatient admission or transfer to another facility for specialized care. By age 50-64, more than 10 percent of all persons receiving a nonfatal injury and treated in a hospital emergency department also require further hospitalization or transfer.

#### *High Rates of Physical Health Problems that Trigger Use of Health Care*

Health care use is tied to health problems, and here, the high rate of chronic illness and physical disability among the U.S. population has been well documented. Furthermore, prevalence increases significantly across the life course. This means that most Americans face health issues that require medical attention and management as they age. Analysis of data from the Americans' Changing Lives Study, a nationally representative longitudinal survey, reveals that the percentage of Americans that can be considered as having physical health problems increases precipitously from young adulthood to old age. "Unhealthy" in this analysis was defined as having a physical impairment or disability, rating one's own health as fair or poor, having a diag-

<sup>41</sup> Kenneth Thorpe and Katya Galactionova, *The Distribution of Health Insurance Coverage Among Pregnant Women in 2007* (March of Dimes, 2010), [http://www.marchofdimes.com/downloads/The\\_Distribution\\_of\\_Health\\_Insurance\\_Coverage\\_among\\_Pregnant\\_Women.pdf](http://www.marchofdimes.com/downloads/The_Distribution_of_Health_Insurance_Coverage_among_Pregnant_Women.pdf) (Accessed Jan. 3, 2012).

<sup>42</sup> *Id.* Chart 4.1.1.

<sup>43</sup> *Id.* Chart 4.4.1.

<sup>44</sup> 42 U.S.C. § 1395dd (2010).

<sup>45</sup> 2010 National Electronic Injury Surveillance System—All Injury Program (NEISS-AIP).

<sup>46</sup> Overall All Injury Causes, Nonfatal Injuries: 2010, United States, All Races, Both Sexes, Ages 0 to 85+, Disposition: All Cases. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

**Figure 2. Non-Fatal Injuries by Age Group**

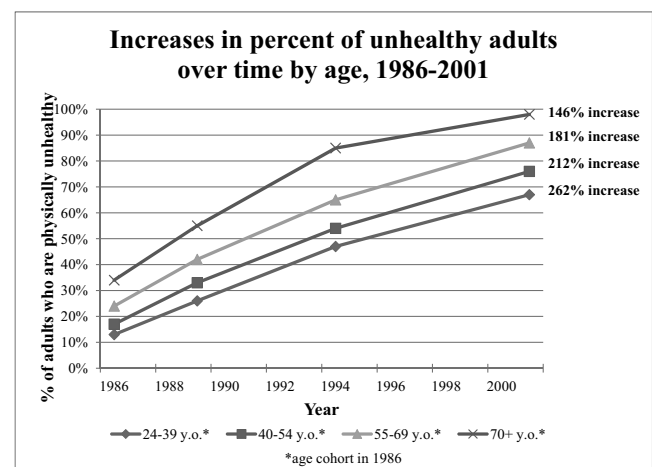
Age Group	Percent of non-fatal injuries that are hospitalized or transferred to another facility in 2010
<30	4.0%
30-49	7.4%
50-64	10.3%
Overall	7.2%

*Percentage of Non-Elderly Adults with Non-Fatal Injury Treated in a Hospital Emergency Department by Age Group, 2010. Source: 2010 National Electronic Injury Surveillance System - All Injury Program (NEISS-AIP).*

nosis of cancer, diabetes, stroke or heart disease, and/or not dying between study waves.

As shown in **Figure 3**, over the 15 -year time period of the Americans' Changing Lives Study, the proportion of adults who can be considered "unhealthy" increased significantly over time in all age groups. **Figure 3** shows that by age 50, the majority of Americans face one or more serious physical health risks or conditions that require medical care and attention. For example, while only slightly more than 10 percent of individuals falling into the 24-39 age cohort in 1986 experienced serious physical health problems requiring medical attention, by 2001 this group experienced a 262 percent rise in the presence of physical health problems, with the proportion of those over the 15-year period surpassing 30 percent. In the case of persons falling into the 40-54 age cohort in 1986, the proportion of persons that can be labeled as being unhealthy rose from 26 percent in 1986 to 55 percent in 2001, a 212 percent increase. Note that the proportion of the population considered "unhealthy" would be even higher if mental health problems and other common chronic conditions such as asthma, arthritis, and obesity were to be considered.

**Figure 3. Health Status Over the Life Course**



*Proportion of Adults in Age Cohorts Who Are Physically Unhealthy Over Time, American Changing Lives Study, 1986-2001*

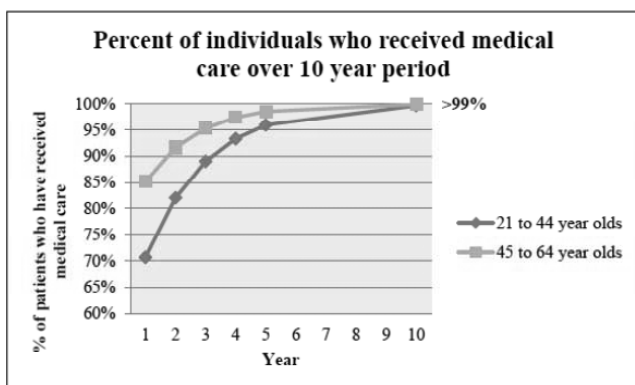
Analyses of the 2010 National Health Interview Survey further reveal the inexorable effects of aging on health status. Almost half (48 percent) of Americans ages 40-49 report ever having a serious chronic disease

such as diabetes, cancer, arthritis or asthma.<sup>47</sup> The level of chronic disease burden rises as people age, increasing to two-thirds (67 percent) for those in their 50s and to over three-quarters (77 percent) of those ages 60 to 64.

### Use of Medical Care Over Time

Undergirding the evidence related to the need for health care is the fact that, as with births, over time, the use of health care is an absolute inevitability. In any given year, a certain proportion of people will go without health care because they are relatively healthy or perhaps because they cannot afford care they are uninsured. However, the avoidance of medical care cannot last for long and virtually everyone eventually participates in the health care marketplace over a multi-year period. Data from MEPS, presented in **Figure 4**, show that among nonelderly adults (those at greater risk for lack of insurance), virtually all individuals will receive medical care at some point over a 10-year time period.<sup>48</sup> Even among younger adults, as **Figure 4** indicates, the proportion that can be classified as non-users at the end of a 10-year timespan reaches a vanishing point; by the 10th year, virtually the entire population of nonelderly adults, including the younger adults, has received medical care.

Figure 4. Medical Care Use Over Time



The George Washington University's analysis of 2007-8 Medical Expenditure Panel Survey (MEPS) data.

<sup>47</sup> Data are based on our analyses of the National Health Interview Survey, a nationally representative survey conducted by the Centers for Disease Control and Prevention, which examines people's health status and medical conditions. The chronic conditions considered in this analysis included arthritis, asthma, cancer, coronary heart disease and relative cardiovascular problems, emphysema, hypertension, and stroke.

<sup>48</sup> This is based on our analyses of merged 2007-8 Medical Expenditure Panel Survey data for nonelderly adults who participated in the survey for both years. We conducted analyses of the percentage of people who went without medical care (including ambulatory or inpatient medical care or prescription drugs, but not including dental care) in 2007 and the additional percentage who went without care in 2008. Based on the marginal probability of going without care in the two years, we estimated the percentage who would go without care over 10 years. The findings were almost exactly the same when we analyzed the proportion of people who had no medical expenditures over the period.

### The Interstate Nature of Health Care Use

A final fact worth observing is the flow of the population using health care across state lines, elevating the economic concern regarding the spillover impact of being uninsured from being one of purely local dimension to one that substantially affects commerce. Modern Americans are mobile and frequently move from one state to another, whether for long-term or short-term reasons. These interstate movements have repercussions for health care needs, as well as for the costs of medical care services used. Analysis of the Census Bureau's American Community Survey<sup>49</sup> shows that in 2009, 6.5 million nonelderly individuals (children and nonelderly adults) relocated from one state to another in 2009.<sup>50</sup> The data indicate that those who cross state lines are about one-third more likely to be uninsured than those who stay within a single state. Some 23.9 percent of those who moved across state lines that year were uninsured, compared with 17.3 percent of those who did not cross state lines.

Beyond general mobility is the challenge of general interstate travel and the use of medical care, particularly in light of hospitals' EMTALA obligations. People may need medical care when they travel, and uninsured travelers create uncompensated care problems when they move from their home state into the health care market of another state. Medical emergencies do not respect state boundaries and often afflict short-term travelers. The magnitude of this problem is illustrated by a recent study that examined emergency hospital admissions.<sup>51</sup> From 1996 to 2003, out-of-state tourists (those who listed their residences as being outside the state of Florida) experienced 36,800 hospital admissions following a medical emergency. The proportion of persons hospitalized as a result of medical emergencies who appeared to be uninsured was more than one-fifth higher among the out-of-state visitors (7.4 percent of out-of-state resident admissions uninsured compared to 6.1 percent of in-state admissions uninsured).

### How the Courts of Appeals Have Approached Problem Definition in Characterizing the Mismatch Between Health Care Financing and the Need for and Use of Health Care

The three appellate courts to have reached the merits of the constitutional claim regarding the minimum essential coverage requirement present a stark contrast in problem definition, a fact that helps illuminate the different conclusions they reached. The Courts of Appeal for both the Sixth and D.C. circuits, both of which upheld the constitutionality of the coverage requirement, launched their analyses from a beginning vantage point

<sup>49</sup> The American Community Survey is conducted in an ongoing basis by the Census Bureau and collects nationally representative data for about 3 million people, making it among one of the largest federal surveys.

<sup>50</sup> These analyses were conducted by George Washington University researchers using 2009 American Community Survey Public Use Microdata Sample (ACS-PUMS) from the U.S. Census Bureau.

<sup>51</sup> Joseph Doyle, *Returns to Local Area Health Care Spending: Evidence from Health Shocks to Patients Far from Home*, AMERICAN ECONOMIC JOURNAL: APPLIED ECONOMICS 3(3): 221-43, July 2011.

that cast the issue as one of how to square health care financing with the reality of Americans' participation in the market for health care, much the way the Supreme Court squared the behavior of the wheat farmer in *Wickard* with the larger commercial market for wheat. In *Thomas More v. Obama*, the Sixth Circuit was particularly clear about the conceptual framework under which it was operating. In examining commerce clause jurisprudence, the majority wrote that:

There is debate over whether the [minimum essential coverage] provision regulates activity in the market of health insurance or in the market of health care. In the most literal, narrow sense, the provision might be said to regulate conduct in the health insurance market by requiring individuals to maintain a minimum level of coverage. However, . . . [t]he Act considered as a whole makes clear that Congress was concerned that individuals maintain minimum coverage not as an end in itself, but because of the economic implications on the broader health care market. Virtually everyone participates in the market for health care delivery and they finance these services by either purchasing an insurance policy or by self-insuring. Through the practice of self-insuring, individuals make an assessment of their own risk and to what extent they must set aside funds or arrange their affairs to compensate for probably future health care needs. Thus, set against the Act's broader statutory scheme, the minimum coverage provision reveals itself as a regulation of the activity of participating in the national market for health care delivery and specifically, the activity of self-insuring for the cost of these services.<sup>52</sup>

In his concurring opinion in *Thomas More*, Judge Jeffrey Sutton emphasized the same focus on the broader health care market (in which all Americans participate) rather than the more limited market for health insurance (in which some Americans do not):

As the claimants see it, Congress's authority to "regulate" interstate "commerce" extends only to individuals already in the stream of the relevant commercial market, in this instance health insurance. It no more permits Congress to conscript an individual to enter that market on the buy side than it permits Congress to require a company that manufactures cars to peddle health insurance on the sell side. . . . The issue is not that simple, the government responds. What has principally changed over the last two centuries is commerce. Even accepting the claimants' characterization of the law as regulating "non-activity," the law still concerns individual decisions that, when aggregated, have a substantial effect on interstate commerce. Individuals cannot disclaim the need to obtain health care and to pay for it, as virtually everyone at some point will consume healthcare services. . . . In my opinion, the government has the better of the arguments.<sup>53</sup>

In *Seven-Sky v. Holder*, the D. C. Circuit followed a similar pathway, away from a narrow definition of the purpose of the law and toward one that embraced a broader view of the subject to be regulated (i.e., of regulating participation in the market for health care, rather than the narrower matter of being required to enter the market for health insurance alone). The majority opinion framed the law as follows: "[T]he Affordable Care Act sought to reform our nation's health insurance and health care delivery markets with the aims of improving access to those markets and reducing health care costs

and uncompensated care."<sup>54</sup> Furthermore, in rejecting the challengers' narrowly drawn claims that the law pushes Americans into a market for insurance rather than regulating their relationships to the health care market as a whole, the majority concluded that the case was not simply about whether or not to buy health insurance, but how to pay for health care services. In the end, the majority wrote, "the only thing that matters is whether the national problem Congress has identified is one that substantially affects interstate commerce."<sup>55</sup> For the D.C. Circuit, it was "irrelevant that an indeterminate number of healthy, uninsured persons will never consume health care and will therefore never affect the interstate market. Broad regulation is an inherent feature of Congress's constitutional authority in this area; to regulate complex, nationwide economic problems is to necessarily deal in generalities."<sup>56</sup>

By contrast, the Eleventh Circuit, in *Florida v. HHS*, focused tightly on what the majority perceived as the Act's requirement that individuals enter the market for health insurance from a point of economic inactivity. Indeed, the majority opinion explicitly rejected any link between the coverage requirement and individuals' activity in the broader economic market:

Congress, in exercising its commerce authority, must be careful not to sweep too broadly by including within the ambit of its regulation activities that bear an insufficient nexus with interstate commerce. . . . In this regard, the individual mandate's attempts to reduce the number of uninsured and correct the cost-shifting problem is woefully overinclusive. The language of the mandate is not tied to those who do not pay for a portion of their health care (i.e. the cost shifters). It is not even tied to those who use health care. Rather, the language of the mandate is unlimited, and covers even those who do not enter the health care market at all. . . . [T]he Act contains no language 'which might limit its reach to a discrete set of [activities] that additionally have a connection with or effect on interstate commerce. . . . Because the Supreme Court's prior Commerce Clause cases all deal with already-existing activity – not the mere possibility of future activity (in this case, health care consumption) that could implicate interstate commerce – the Court never had to address any temporal aspects of congressional regulation. However, the premise of the government's position – that most people will, at some point in the future, consume health care – reveals that the individual mandate is even further removed from traditional exercises of Congress's commerce powers.<sup>57</sup>

Of course, it is possible that the Supreme Court could define the market that is the subject of ACA regulation in a more narrow way while nonetheless finding that the act of not buying insurance is an economic decision, a conclusion reached by Judge Sutton in his *Thomas More* concurrence.<sup>58</sup> But the structure of the Act—a fundamental re-calibration of the law insofar as health insurance coverage and health care are concerned—coupled with the congressional findings that form its basis, as well as extensive evidence of the inevitable, immediate, and universal need for and use of health care, combine to create a powerful argument that the framework for analyzing the constitutionality of the minimum essential coverage requirement should be the

<sup>54</sup> *Seven-Sky v. Holder* 661 F.3d at 3.

<sup>55</sup> *Id.* at 19.

<sup>56</sup> *Id.* at 21.

<sup>57</sup> *Florida v. HHS*, 648 F.3d at 1293-1294.

<sup>58</sup> *Thomas More Law Center v. Obama* 651 F.3d at 556-557.

<sup>52</sup> *Thomas More v. Obama*, 651 F.3d at 543.

<sup>53</sup> *Id.* (Sutton, J. concurring) at 549-550 and 556.

stability of the larger health care economy, of which insurance plays a crucial financial role.

### **Concluding Thoughts**

In the Patient and Protection and Affordable Care Act, Congress achieved a new milestone in U.S. health policy. This milestone takes the shape of legislation that, crafted as a single major reform effort, is designed to stabilize health care for all Americans by addressing the multiple and highly connected dimensions of the modern American health care enterprise. At the core of the legislation are interventions that will, when fully implemented, bring stability to health care coverage and costs by strengthening the risk pooling system on which health insurance rests while opening up new financing pathways for millions currently excluded from existing public and private coverage arrangements. Built around this core are reforms aimed at achieving even deeper structural change in how health care is organized and delivered in order to promote both quality and efficiency. These investments are accompanied by

an expansion of the range of interventions available to improve the public's health.

The principal thrust of the Supreme Court phase of the Affordable Care Act will be its constitutional basis; by definition, the judicial phase of the legislation focuses on its legal basis. As of June, the public most likely will know whether the court's message will be to proceed with implementation or to return to the legislative enterprise to correct what the court concludes are constitutional flaws in structure and design. The answer to this question, at least insofar as the minimum essential coverage requirement is concerned, depends on how the court frames the problem that the Act is meant to solve, as well as how it assesses the constitutionality of a unique solution that has been structured to reflect the strong market orientation of the modern U.S. health care system. From a broader health policy perspective, the message of the Affordable Care Act is that health insurance is only the first and most essential step in positioning the broader health care market to be able to respond to the deep challenges of access, cost, quality, and health outcomes that lie ahead.