No. 11-398

In The Supreme Court of the United States

DEPARTMENT OF HEALTH & 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 FOR DOCS4PATIENTCARE, BENJAMIN RUSH SOCIETY, PACIFIC RESEARCH INSTITUTE, GALEN INSTITUTE, AND ANGEL RAICH AS *AMICI CURIAE* ON THE MINIMUM COVERAGE PROVISION ISSUE IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE* [1]

Amicus Curiae Docs4PatientCare is a non-profit 501(c)(6) membership organization of concerned physicians committed to the establishment of a health care system that preserves the sanctity of the doctor-patient relationship, promotes quality of care, supports affordable access to all Americans, and protects patients' freedom of choice. It has an interest in this case because the individual mandate contradicts these fundamental principles and sets a dangerous precedent regarding the inappropriate use of federal power to dictate the choices of Americans.

Amicus Curiae Benjamin Rush Society is a membership organization that includes medical students, residents, fellows, and doctors across the political spectrum — as well as members of the general public — who believe that the profession of medicine calls its practitioners to serve their patients, rather than the government. The Society believes that the physician-patient relationship is a voluntary and mutually beneficial one. Both parties have a right to enter this relationship freely. The proper role of government is to protect this freedom, not to diminish it. The Society is part of the Pacific Research Institute. The Society is interested in this case because the individual mandate undermines such freedom by compelling

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[1] No counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amici* or their counsel, make a monetary contribution intended to fund the preparation or submission of this brief. This brief is submitted pursuant to the blanket consent letters from all parties, on file with this Court.

some individuals to purchase health insurance notwithstanding their free choice to the contrary.

The Pacific Research Institute is a non-profit nonpartisan 501(c)(3) organization that champions freedom, opportunity, and personal responsibility by advancing free-market policy solutions to the issues that impact the daily lives of all Americans. It demonstrates how free interaction among consumers, businesses, and voluntary associations is more effective than government action at providing the important results we all seek—good schools, quality health care, a clean environment, and economic growth. Founded in 1979 and based in San Francisco, PRI is supported by private contributions. Its activities include publications, public events, media commentary, invited legislative testimony, and community outreach.

The Galen Institute is a non-profit, Section 501(c)(3) public policy research organization devoted to advancing ideas and policies that would create a vibrant, patient-centered health sector. It promotes public debate and education about proposals that support individual freedom, consumer choice, competition, and innovation in the health sector. It focuses on individual responsibility and control over health care and health insurance, lower costs through competition, and a reliable safety net for vulnerable populations. Galen's policies promote continued medical innovation, advances in personalized medicine, and expanded access to health care and coverage in the 21st century Information Age economy.

Angel McClary Raich was the lead respondent in one of this Court's important recent Commerce

Clause cases, *Gonzales* v. *Raich*, 545 U.S. 1 (2005). She suffers from terminal cancer and the related effects of radiation and chemotherapy. She thus brings to this case the perspective of both a patient in our healthcare system and a litigant with a personal understanding of the implications of an expansive construction of the Commerce Clause on individual freedom. Her interest in this case stems from both her belief that the individual mandate will worsen, rather than improve, the problems in our healthcare system, and from her concern that the government's expansive views of the Commerce and Necessary and Proper Clauses will lead to the limitless federal power against which she warned in her own case before this Court.

None of the above *amici* is publicly traded or has any parent corporations, other than as noted, and no publicly traded corporation owns 10% or more or any of the above *amici*.

SUMMARY OF ARGUMENT

1. Petitioners' claim that the individual mandate is needed to avoid the supposedly significant market effects of cost-shifting by the uninsured both exaggerates the amount of the problem potentially affected by the mandate and fails to recognize that the mandate actually *increases*, rather than reduces, any claimed cost-shifting to private parties. Rather than play any meaningful role in addressing the claimed $43 billion in uncompensated care consumed by 50 million uninsured, the mandate only changes the behavior of 16 million uninsured persons who consume at most only $9.5 billion in uncompensated care.

Furthermore, because 6.5 million of those 16 million uninsured persons will enroll in Medicaid, rather than obtain private insurance, they will actually consume more uncompensated care than the entire 16 million persons did without insurance, for a net increase in uncompensated care of between $0.5 and $3 billion. That perverse result occurs because their average consumption of healthcare will double and because doctors and hospitals receive a significantly lower rate of compensation for Medicaid patients than they do for the uninsured. The net consequence of the mandate on the 16 million uninsured as a whole, therefore, has no substantial effect on the claimed commerce problem of cost-shifting other than to make it worse. Given the disconnect between the alleged problem affecting interstate commerce and the proposed solution, the mandate has no tangible link or rational relationship to the Commerce Clause and is not necessary and proper to deal with the alleged problem of cost shifting.

2. Nor is the mandate necessary and proper to "carry[] into Execution" the new insurance restrictions contained in the Act. While petitioners claim that the mandate is needed to avoid the destructive effects of adverse selection resulting from the Act's must-issue and community-rating requirements, that argument misconceives the scope of the Necessary and Proper Clause. That Clause permits such additional authority as is necessary and proper for "carrying into Execution" an enumerated power such as the commerce power. The mandate, however, does nothing to help "Execut[e]" the new insurance rules. Rather, its sole purpose is to avoid or offset the natural

consequences that flow *from* the full execution of such rules.

Petitioners' claim to any authority that allows Congress to achieve its goals or "ends" in connection with a regulation of commerce misconceives the meaning of the constitutional phrase "carry[] into Execution" and would render Congress's authority unlimited: *Any* conceivable policy goal or "end" could be ascribed to a regulation of commerce, at which point Congress could claim all further authority it deemed desirable for achieving that goal or end. Indeed, the less effective a legitimate exercise of authority was at achieving a particular policy outcome, the greater would be Congress's claim to more unenumerated power under petitioners' theory. Such a "bootstrapping" approach to expanding congressional power is inconsistent with both the text and history of the Necessary and Proper Clause and the fundamental logic of the Constitution.

ARGUMENT

Two of petitioners' primary Commerce Clause justifications for the individual mandate are: (1) that the failure to purchase insurance shifts costs to other private participants in the insurance market, and hence the mandate regulates behavior having a substantial effect on interstate commerce; and (2) that the mandate is required to avoid the destructive effects of new federal insurance rules imposed by the Act, and hence the mandate is necessary and proper

to effectuate those rules. Pet Br. (Min. Cov.) at 18-19.[2]

Neither of those justifications, however, is based on the Commerce Clause directly, but both are instead based on extensions of the commerce power via the Necessary and Proper Clause. Regarding activities that have a "substantial effect" on interstate commerce, Justice Scalia has explained that

> unlike the channels, instrumentalities, and agents of interstate commerce, activities that substantially affect interstate commerce are not themselves part of interstate commerce, and thus the power to regulate them cannot come from the Commerce Clause alone. Rather, * * * Congress's regulatory authority over intrastate activities that are not themselves part of interstate commerce (including activities that have a substantial effect on interstate commerce) derives from the Necessary and Proper Clause. * * *.

Gonzales v. *Raich*, 545 U.S. 1, 34 (2005) (Scalia, J., concurring in the judgment) (citations omitted).

Similarly, the power to regulate behavior in order to effectuate a separate and otherwise proper regulation of commerce derives from the language of the Necessary and Proper Clause itself – granting Con-

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[2] This brief does not address petitioners' further claim that the mandate is a direct regulation of the means of paying for commerce in healthcare. That issue is addressed by respondents and numerous other *amici*. This brief assumes that the mandate will not be deemed a direct regulation of interstate commerce and addresses only petitioners' arguments that assert authority beyond that provided by the Commerce Clause alone.

gress authority to "make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers," Art I, sec. 8, cl. 18 – as has been recognized by this Court since *McCulloch* v. *Maryland,* 17 U.S. (4 Wheat.) 316 (1819).

For a statute to be authorized under the Necessary and Proper Clause, it must "constitute[] a means that is rationally related to the implementation of a constitutionally enumerated power." *United States* v. *Comstock*, 130 S. Ct. 1949, 1956 (2010). Unlike the more lenient rational basis test applied in the Due Process Clause context, however, the rational relationship needed to expand the reach of the Commerce Clause requires

> a tangible link to commerce, not a mere conceivable rational relation, * * *. " '[S]imply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily make it so.' " * * * The 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) (citations omitted).

With those standards in mind, neither of petitioners' claims to penumbral Commerce Clause authority via the Necessary and Proper Clause is sufficient. The individual mandate is not "rationally related" to addressing the claimed problem of cost-shifting by the uninsured. Failures of basic arithmetic in the reimbursement data cited by the government, and the exclusion of *increased* cost-shifting caused by the mandate itself, show that there is no "demonstrated

link in fact" between the uninsured who are impacted by the individual mandate and any decrease in cost shifting that might substantially affect interstate commerce.

Furthermore, a fundamental confusion between facilitating the *exercise* of the commerce power over the sale of insurance and altering the *policy outcomes* of such exercise shows that the individual mandate does not serve to "carry[] into Execution" the regulation of insurance under the commerce power.

I. The Individual Mandate Has No Demonstrated Link to Reducing Any Cost Shift to Private Insurance, and in Fact Worsens the Asserted Problem.

Petitioners make a variety of economic claims in support of their argument that the mandate is necessary to reduce the effects on commerce from cost shifting between the uninsured and the insured. Citing a study by Families USA, petitioners claim that 50 million uninsured individuals annually consume $116 billion in healthcare, $43 billion of which is uncompensated, "*i.e.*, care received by uninsured patients but not paid for by them or by a third party on their behalf." Pet. Br. (Min. Cov.) at 7-8 (*citing*, *inter alia*, Families USA, *Hidden Health Tax: Americans Pay a Premium*, at 2, 6 (2009)). Petitioners then claim that such uncompensated costs are passed on to private insurers, who in turn pass it on to insurance purchasers, resulting in an increase in average family premiums of over $1,000 per year. Pet. Br. (Min. Cov.) at 8 (citing 42 U.S.C.A. § 18091(a)(2)(F); Families USA, *Hidden Health Tax*, at 2, 6). The govern-

ment has claimed that the Act *as a whole* will result in an additional 34 million people obtaining coverage by 2021, 17 million of which will be covered through expanded Medicaid and CHIP coverage, the remainder through newly obtained private insurance. CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010* (March 30, 2011), at 1.

Those numbers exaggerate the problem that the mandate is claimed to address and overstate the extent to which the mandate even potentially rectifies the asserted problem. The claimed amount of uncompensated care consumed by the uninsured, for example, excludes $13 billion in additional existing government payments that offset the cost of treating the uninsured. And the claim that 34 million uninsured will obtain coverage misleadingly aggregates the effects of the Act as a whole, rather focusing on the distinct effects of the individual mandate – both positive and negative – on uncompensated care.

As discussed below, looking to the facts and as revealed in the government's own data, the demonstrable amount of total uncompensated care for the uninsured is only $30 billion. The mandate itself only results in new coverage for 16 million persons who would have consumed, at most, $9.5 billion in uncompensated care. Because 6 to 7 million of the 16 million persons affected by the mandate will obtain new coverage through Medicaid – which notoriously undercompensates for medical services – and increase their total consumption of healthcare, they will actually generate a *net increase* in uncompensated care, rather than a reduction. And that net increase in uncompensated care turns out to be greater

than any reduction in uncompensated care from the remainder of the 16 million uninsured who will obtain private insurance as a result of the mandate.

Thus, by only partially addressing an exaggerated problem in a counterproductive way, the mandate lacks a rational relationship to addressing any problem with a substantial effect on commerce.

A. The Amount of Uncompensated Care Is Exaggerated Because It Ignores Existing Sources of Funding for the Care of the Uninsured.

The government claims that 50 million uninsured consume $116 billion, or an average of $2,320 per person, of healthcare, of which $43 billion, or $860 per person is uncompensated. Pet. Br. (Min Cov.) at 19.

That claim, however, relies on the assertion that only $30 billion of the cost of care for the uninsured is paid by third-party sources such as government programs and charities. *Id.* at 8 (citing Families USA, *Hidden Health Tax*, at 2, 6). [3] That figure, however,

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[3] We do not discuss the government's cost of paying for uncompensated care to the uninsured because petitioners' cost-shifting theory and Congress's findings on which they rely turn only on costs paid by private market participants, not by governments or charities. But to the extent that the costs shifted to the government were relevant for Commerce or Necessary and Proper Clause purposes, suffice it to say that the individual mandate, even with its penalty provisions, does not ameliorate such costs but in fact exacerbates them. As the CBO has recognized, the individual mandate will impose a net cost to the federal government of $252 billion dollars between 2014, when it becomes effective, and 2020. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010),

excludes numerous government and private funding sources that offset the cost of care for the uninsured, such as state and local payments to hospitals and support for indigent care, direct care programs that serve the uninsured, the federal government's Community Health Centers program, AIDS and HIV programs, Maternal and Child Health Block Grants, and the National Health Service Corps.

In a study sponsored by the Kaiser Commission on Medicaid and the Uninsured, Professor Jack Hadley and his colleagues added together these multiple sources of government funding for care of the uninsured, in addition to the sources considered in the Families USA study, and found that the government provides $42.9 billion in funding that supports care for the uninsured.[4]

Once the full, actual amount of third-party payments for the uninsured is taken into account, the amount of uncompensated care substantially declines. Even using the government's starting points for consumption and patient out-of-pocket payments,

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at 1-2. Such costs overwhelmingly exceed any current government outlays for those uninsured affected by the mandate.

And that additional cost does not even take into account the billions of dollars in costs shifted to the States as a result of the Medicaid expansion and the increased utilization of Medicaid caused by the mandate and other parts of the health-care law.

[4] Jack Hadley, John Holahan, Teresa Coughlin & Dawn Miller, *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage*, at 26-47, 51 (Kaiser Commission on Medicaid and the Uninsured, August 2008), available at http://www.kff.org/uninsured/upload/7809.pdf.

there is only $30 billion in uncompensated care potentially shifted via higher insurance premiums. That amounts to only 26% of consumption and $600 per person in uncompensated care.

Tables 1 and 2 summarize the calculations:

Table 1: Uncompensated Care – Government Figures			
	Dollars (billions)[5]	%	Per Person
50 million uninsured			
Consumption	116	100	$2,320
Patient payments	43	37	$ 860
Third-Party Payments	30	26	$ 600
Uncompensated Care	**43**	**37**	**$ 860**

Table 2: Uncompensated Care Including Additional Third Party Payments per Hadley, *et al.*			
	Dollars (billions)	%	Per Person
50 million uninsured			
Consumption	116	100	$2,320
Patient Payments	43	37	$ 860
All Third-Party Payments	43	37	$ 860
Uncompensated Care	**30**	**26**	**$ 600**

[5] Total dollars in these tables, and in Table 3 on page 19, are rounded to the nearest half-billion. Percentages are rounded to the nearest percent

B. The Individual Mandate Addresses Only a Fraction of the Alleged Problem.

In addition to overstating the total amount of uncompensated care consumed by the uninsured, petitioners' figures also are misleading in citing the total amount of uncompensated care as justification for the mandate when the mandate itself only causes less than a third of the 50 million uninsured to obtain new coverage.

Indeed, petitioners quietly concede this point in a footnote late in their brief, admitting that the individual mandate is responsible for only 16 million new people obtaining coverage by 2019. Pet. Br. (Min Cov.) at 32-33 n. 7 (citing the "expert judgment" of Congressional Budget Office ("CBO") projections contained in CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010,* at 18 (March 30, 2011), and CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010).[6]

Those 16 million account for only $9.6 billion in uncompensated care.[7] That is far less than the $43 billion figure petitioners start with.

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[6] The CBO's estimate of 34 million persons with new coverage by 2021, *supra* at 8-9, includes many persons who will voluntarily obtain coverage based on other changes made by the Act, regardless of the mandate.

[7] This figure is obtained by multiplying 16 million persons by the per-person uncompensated care figure of $600, *supra* at 12, Table 2.

For ease of calculation we have conservatively assumed that the per-person costs of uncompensated care are equally distributed among the uninsured. However, that assumption likely

But even that number is exaggerated in that it does not account for *increases* in uncompensated care also caused by the mandate.

C. The Mandate Exacerbates Cost Shifting by Increasing Consumption of Under-Reimbursed Services.

When considering the issue of uncompensated care, the government blithely assumes that coverage is tantamount to compensation, and that every patient covered will reduce the amount of uncompensated care. That assumption has no demonstrable basis in fact and, according to the government's own sources, is wrong.

The problem with the government's assumption is that many of the 16 million persons influenced by the mandate will sign up for Medicaid, rather than obtain private insurance coverage. That will result in increased consumption, decreased provider compensation, and a net increase in total uncompensated care as a result of the individual mandate.

As the government's own data recognize, of the 16 million individuals who will get coverage due to the

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overestimates the effect of the individual mandate on the amount of uncompensated care received by those whose behavior will be changed by the mandate. Many of the 16 million uninsured pressed by the mandate into obtaining private or employer-based coverage likely consume less healthcare than the average uninsured, and likely paid out of pocket a higher than average percentage of their healthcare costs while uninsured. Those persons thus consumed less than their pro-rata share of uncompensated care, and removing them from the pool of the uninsured will have a smaller impact in reducing uncompensated care.

mandate, 6 to 7 million will obtain governmental coverage under Medicaid and the Children's Health Insurance Program (CHIP). CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2. With respect to these persons, the individual mandate will actually increase the amount of uncompensated care because such coverage simultaneously increases their consumption of healthcare services yet systematically under-compensates providers for such services.

It is well recognized that the uninsured consume approximately 50% less healthcare than do the insured.[8] Once covered by government programs – under which they would pay little or nothing for healthcare – the newly covered can be expected to double their consumption.[9]

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[8] Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System*, ISSUE BRIEF # 3, at 2 (New America Foundation Dec. 2006), http://www.newamerica.net/files/HealthIBNo3.pdf (uninsured nationally receive an average of 50% of the care received by the insured) (citing for Agency for Healthcare Research and Quality, *Research Findings #27: Health Care Expenses in the United States, 2000* (April 2004), http://www.meps.ahrq.gov/data_files/publications/rf21/rf21.shtml.); Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use and Who Pays for It?*" 2003, HEALTH AFFAIRS, at W3-69 to W3-70, http://content.healthaffairs.org/content/early/2003/02/12/hlthaff.w3.66.full.pdf (full year uninsured received about half as much care as the privately insured).

[9] Much of the differential consumption is attributable to lack of access to and resources for health care, particularly for low-income uninsured. For higher income uninsured, however, those choosing to forego insurance are, on average healthier, though the 50% consumption differential between insured and unin-

While such consumption will now be covered under Medicaid and CHIP, it is also well recognized that Medicaid systematically underpays for healthcare services, on average paying only 72% of the amounts paid by Medicare, which itself pays only 80% of what is paid by private insurers.[10] That amounts to Medicaid paying, on average, only 58% of what private insurers pay – a 42% underpayment. Even petitioner

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sured holds even controlling for health. Hadley, *et al.*, *Covering the Uninsured in 2008*, at 19 ("the uninsured use less care than the insured (holding health status constant), because they pay for much of their care themselves and because their health is generally better than the insured's"). Persons who would receive governmental insurance under the mandate, however, fall into the former group, with consumption likely a function of resources and having to internalize much of the cost of care. Once they are under governmental coverage for which they do not have to pay, their consumption of healthcare that is now entirely free to them will rise.

[10] David Olmos, *Mayo Clinic in Arizona to Stop Treating Some Medicare Patients*, Bloomberg, December 31 2009, ("Nationwide, doctors made about 20 percent less for treating Medicare patients than they did caring for privately insured patients in 2007, a payment gap that has remained stable during the last decade"), *available at* http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aHoYSI84VdL0; Stephen Zuckerman, Aimee F. Williams & Karen E. Stockley, *Trends in Medicaid Physician Fees 2003-2008*, HEALTH AFFAIRS, April 28, 2009, at w510 (Medicaid fees were only 72% of Medicare fees in 2008), *available at* http://content.healthaffairs.org/content/28/3/w510.full.html; Colorado Children's Healthcare Access Program, *Compare: Reimbursement for Medicaid Versus Commercial Health Insurance Versus Office Expenses*, CCHAP Newsletter Three – Article 1, January 2007, at 2 (reimbursement rates for pediatric care routinely less than half of commercial rates and rarely above 80% of commercial rates), available at http://www.cchap.org/newsletter-three/#one.

HHS itself optimistically pegs Medicaid payments at between 58% to 66% of private health insurance payments, a 34% to 42% underpayment.[11]

Combining the nature of coverage caused by the mandate, the increased consumption, and the Medicaid under-compensation rates yields a startling result. Rather than consuming roughly $4 billion in uncompensated care when they were uninsured,[12] the 6.5 million persons who will enroll in Medicaid as a result of the mandate will consume between *$10 billion and $12.5 billion* in uncompensated care.[13] For

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[11] John D. Shatto & M. Kent Clemens, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Office of the Actuary, Centers for Medicare and Medicaid Services, HHS, May 13 2011, at 6-7 (Medicaid payment rates of 66% of private insurance rates for hospital inpatient services and 58% for physician services), available at https://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf.

[12] 6.5 million persons x $600 per person uncompensated care, *supra*, at 12, Table 2.

[13] Using the middle of the CBO's range of persons shifting to Medicaid, the calculation is as follows: 6.5 million persons x $2420 per person consumption x 2 x (0.34 to 0.42 undercompensation rate). These figures do not provide any further reduction for other government programs that might indirectly subsidize such undercompensation for two reasons. First, the HHS figure cited in footnote 11 already includes Medicaid disproportionate share payments, which are part of the government compensation included by both Hadley and Families USA. John D. Shatto & M. Kent Clemens, *Projected Medicare Expenditures*, at 6. Second, most of the other government programs and payments included would become largely irrelevant once this group was covered by Medicaid in that they would be able to visit their own physicians and would no longer separately utilize programs for the indigent. The cost of the underpayment thus would be borne

this cohort, the mandate actually makes the problem of uncompensated care far worse than it was before. In fact, the problem is so much worse under Medicaid that the *net* effect for the entire 16 million people affected by the mandate, including those getting private insurance, is an increase in uncompensated care of between $0.5 billion to $3 billion.

Table 3 on the following page summarizes the calculations leading to this conclusion.

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by such physicians rather than any government-funded clinic or similar program.

Table 3: Impact of the Individual Mandate			
	Dollars (billions)	%	Per Person
16 million covered			
Costs Before Mandate			
Consumption	37		$2,320
Reimbursement	27.5	74	$1,720
Uncompensated Care	**9.5**	**26**	**$ 600**
Costs After Mandate			
9.5 million insured			
Consumption	44		$4,640
Reimbursement	44	100	$4,640
Uncompensated Care	**0**	**0**	**$ 0**
6.5 million Medicaid		`	
Consumption	30		$4,640
Reimbursement Range (58%-66%)	17.5 20	58 66	$2,691 $3,248
Uncompensated Care **Range (42%-34%)**	**12.5** **10**	**42** **34**	**$1,949** **$1,569**
Total Consumption of Combined 16 million	74		$4,640
Total Uncompensated Care	12.5 10	17 14	$ 781 $ 638
Net Increase in Uncompensated Care	**3** **0.5**	**32** **0.1**	**$ 181** **$ 38**

Even ignoring the offsetting increase in uncompensated care by individuals joining Medicaid as a result of the mandate, the decrease in uncompensated from 9.5 million individuals getting private insurance as a result of the mandate is only $5.7 billion. That amount is trivial in the context of national spending on healthcare of $2.6 trillion. It amounts to only 0.2% of spending and certainly does not have a *substantial* effect on interstate commerce. In fact, it is effectively a rounding error. But, of course, that decrease is more than offset by the net increase from new Medicaid patients in any event.

Thus, while the mandate will cause 16 million people to obtain coverage, such coverage does not fix the cost-shifting claimed as the basis for Commerce Clause authority, but in fact *increases* the amount of uncompensated care and the costs that are potentially shifted. From the perspective of the Commerce and Necessary and Proper Clauses, the cure is worse than the disease. That would seem to be the antithesis of a rational relationship between the problem of cost shifting affecting interstate commerce and the supposedly necessary and proper means of supplementing the Commerce Clause to address that problem.

Rather than the individual mandate being a means of addressing $43 billion in uncompensated care and supposed cost shifting that significantly affects commerce, it addresses an insubstantial amount of costs that are unlikely to be noticed, much less shifted, and actually *causes* more uncompensated care than it purports to cure. Under the standards for invoking the Necessary and Proper Clause in sup-

port of the Commerce Power, the individual mandate is a total failure. It is not rationally related to the implementation of the commerce power, and its connection to solving any problem that substantially affects commerce has no basis in fact or empirical demonstration.

II. The Individual Mandate Is Not Necessary and Proper to "Carry into Execution" the Commerce Power.

Petitioners also argue that the individual mandate is necessary and proper to avoid the negative consequences of the new insurance rules adopted by the Act. *See* Pet. Br. (Min. Cov.) at 21-30. According to petitioners, the new legislation forbidding insurance companies from denying coverage to persons with pre-existing conditions, and requiring them to price coverage based on community ratings rather than individual risks, creates an incentive for people to forego insurance until after they have already become sick and are about to incur medical expenses. Such so-called adverse selection would make insurance unprofitable and ultimately non-viable.

The individual mandate seeks to avoid this result by requiring insurance coverage at all times, thereby precluding last-minute purchases and providing a guaranteed stream of income to insurance companies from persons who are not consuming as much healthcare as those who are already ill. According to petitioners' theory, adopting the mandate to avoid such self-inflicted consequences "is necessary to make effective the Act's core reforms of the insurance market." Pet. Br. (Min. Cov.) at 24; *id.* at 30 (individual

mandate "is 'necessary' to the end of regulating insurance underwriting practices without running insurers out of business") (citation and internal quotation marks omitted).

The critical flaw in petitioners' analysis is that it confuses an effort to avoid the natural results of its economically destructive insurance rules with "carrying into Execution" such rules. The Necessary and Proper Clause, however, grants only a facilitating power, not a cure-all to ensure favorable results. To read it as petitioners have would render the qualifying language "for carrying into Execution" meaningless, and would effectively grant Congress a police power.

The Necessary and Proper Clause gives Congress authority to "make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers." Art I, sec. 8, cl. 18. To qualify under this grant of authority, a law must not merely be needful or desirable; it must also have as its function "carrying into Execution" one of the enumerated powers. *See McCulloch*, 17 U.S. (4 Wheat.) at 412; *Comstock*, 130 S. Ct. 1949, 1957 (2010). This Clause "is not a self-contained grant of power. It authorizes Congress only to pass laws that 'carry[] into Execution' powers the Constitution elsewhere vests in one or more institutions of the federal government." Gary Lawson & Patricia B. Granger, *The "Proper" Scope of Federal Power: A Jurisdictional Interpretation of the Sweeping Clause*, 43 DUKE L.J. 267, 274 (1993).

The Framers understood that the "for carrying into Execution" qualifier imposed a meaningful limitation on Congress and served to support the protective con-

straints introduced by a scheme of enumerated powers. James Madison, for example, noted that the authority granted by the Necessary and Proper Clause " 'only extended to the enumerated powers. Should Congress attempt to extend it to any power not enumerated, it would not be warranted by the clause.' " Lawson & Granger 43 DUKE L.J. at 275 n. 24 (quoting Statement by James Madison at the Virginia convention in 2 DEBATES IN THE SEVERAL STATE CONVENTIONS ON THE ADOPTION OF THE FEDERAL CONSTITUTION 455 (Jonathan Elliot, ed., 2d ed. 1836) (hereinafter ELLIOT'S DEBATES)). James Wilson similarly noted that the Clause was " 'limited and defined' " by the "for carrying into Execution" language, and Elbridge Gerry explained that the Clause " 'gives no legislative authority to Congress to carry into effect any power not expressly vested by the constitution.' " Lawson & Granger 43 DUKE L.J. at 275 n. 24 (quoting ELLIOT'S DEBATES at 468 and 1 ANNALS OF CONG. 277 (Joseph Gales ed., 1789)).

For the "carrying into Execution" language to have any meaningful function or role, it must be understood in the natural and instrumental sense of allowing Congress to give effect to or implement some other power.

> To carry a law or power into execution in its most basic sense means to provide enforcement machinery, prescribe penalties, authorize the hiring of employees, appropriate funds, and so forth to effectuate that law or power. It does *not* mean to regulate unenumerated subject areas to make the exercise of enumerated powers more efficient.[]"

Lawson & Granger 43 DUKE L.J. at 331 (emphasis in original; footnote omitted).

Once the limitation imposed by the "for carrying into Execution" language is acknowledged, it is apparent that the individual mandate does not carry into execution the new insurance rules. Petitioners do not claim that the new insurance rules would fail to operate, could not be enforced, or otherwise would lack effect absent the mandate. Rather, the very problem they identify is that the new insurance restrictions would be all too effective, and thus have predictably destructive consequences as a result of their operation. What petitioners argue is that absent the mandate the new rules Congress enacted would not be *desirable* and would not accomplish Congress's underlying *policy* goals. But that is not a matter of execution; it is a matter of outcome.

In claiming that the mandate makes the insurance regulations "effective" and supports the congressional "end" of regulating the insurance market without negative consequences, Pet. Br. (min. Cov.) at 24, 30, petitioners seem to be misreading and expanding upon language from *McCulloch*, where Chief Justice Marshall noted:

> We admit, as all must admit, that the powers of the government are limited, and that its limits are not to be transcended. But we think the sound construction of the constitution must allow to the national legislature that discretion, with respect to the means by which the powers it confers are to be carried into execution, which will enable that body to perform the high duties assigned to it, in the

> manner most beneficial to the people. Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.[]

17 U.S. (4 Wheat.) at 421 (footnote omitted).

The "end" to which Chief Justice Marshall was referring in the above passage, however, was not the policy goal of Congress, but rather the *exercise* of an enumerated power. Petitioners do not claim Congress is incapable of exercising its power to regulate insurance absent the mandate. The new insurance restrictions are law, and Congress has chosen the various means it deems most beneficial for carrying them into execution, ranging from reporting requirements and provisions for review and enforcement, to penalties for non-compliance. The exercise of Congressional power is thus fully realized – "carr[ied] into Execution" – without the mandate. It is only the consequences and downstream results of such exercise that Congress seeks to alter with the mandate.

The distinction between the supplemental means for exercising an enumerated power and the substantive ends or outcomes towards which the power is directed can be seen in *McCulloch*'s examples and discussions preceding the quoted passage.

In considering the establishment of a national bank under the Necessary and Proper Clause, Chief Justice Marshall referred back to the power to raise revenues and raise and support armies, and noted that the exercise of such powers "may require, that

the treasure raised in the north should be transported to the south, that raised in the east, conveyed to the west." 17 U.S. (4 Wheat.) at 408. Having the means of paying for the expenses of an army is plainly instrumental to the power to raise an army. But there is no suggestion that the Necessary and Proper Clause would support any other extra-enumerated powers simply to achieve the policy goals for which the army has been raised or deployed. Indeed, Marshall expressly distinguished between the means of implementing a power and the ends for which a power is exercised:

> The power of creating a corporation, though appertaining to sovereignty, is not, like the power of making war, or levying taxes, or of regulating commerce, a great substantive and independent power, which cannot be implied as incidental to other powers, or used as a means of executing them. It is never the end for which other powers are exercised, but a means by which other objects are accomplished. * * * The power of creating a corporation is never used for its own sake, but for the purpose of effecting something else. No sufficient reason is, therefore, perceived, why it may not pass as incidental to those powers which are expressly given, if it be a direct mode of executing them.

Id. at 411.

Other examples described in *McCulloch* highlight that the Necessary and Proper Clause is limited to implementing the exercise of an enumerated power, not guaranteeing any particular outcome from that

exercise. For example, the powers to prescribe oaths of office, to "punish any violations of its laws," and to carry mail and punish those who steal letters from the post office each implements enumerated powers to hold and create offices, legislate on various matters, and establish post offices and post roads. But those examples of supplemental powers do not include the power to take further steps to ensure good outcomes from the underlying exercise. In each instance, the end to which such supplemental powers are directed is the exercise of some enumerated power, not the further "ends" towards which those powers were directed.

Chief Justice Marshall himself later explained how actions designed merely to make an exercise of power more effective, or to accomplish a goal without undue burden, would not constitute a means of executing a given power. Concerning whether Congress could preempt state taxes in order to increase its ability to collect its own taxes without unduly burdening the populace, Marshall explained:

> Now I deny that a law prohibiting the state legislatures from imposing a land tax would be an "appropriate" means, *or any means whatever*, to be employed in collecting the tax of the United States. It is not an instrument to be so employed. It is not a means "plainly adapted," or conducive to[,]" the end.

A Friend to the Union, *reprinted in John Marshall's Defense of McCulloch v. Maryland* 78, 100 (Gerald Gunther ed., 1969) (emphasis added); *see also United States* v. *DeWitt*, 76 U.S. 41, 44 (1869) (rejecting a ban on intrastate sales of certain products unsuccess-

fully justified as a means to increase demand for other products subject to federal taxation and thereby "aid and support" and make more "effective" the "power of laying and collecting taxes").

More recently, in *Comstock*, Justice Alito emphasized the "carrying into Execution" aspect of the Necessary and Proper Clause when he "agree[d] with the dissent that '[t]he Necessary and Proper Clause empowers Congress to enact only those laws that "carr[y] into Execution" one or more of the federal powers enumerated in the Constitution.' " 130 S. Ct. at 1969 (Alito, J., concurring in the judgment). He correctly recognized that the "The Necessary and Proper Clause provides the constitutional authority for most federal criminal statutes. * * * [I]n order to execute one or more of the powers conferred on Congress, it is necessary and proper to criminalize certain conduct, and in order to do that it is obviously necessary and proper to provide for the operation of a federal criminal justice system and a federal prison system." *Id.* On this view, the law at issue in *Comstock* thus was merely an incidental part of operating a federal prison system, and thus served to execute, by means of effective enforcement, the underlying laws enacted pursuant to Congress's enumerated powers.

In their dissent in *Comstock*, Justices Thomas and Scalia placed an even greater emphasis on the "carrying into Execution" limitation on the Clause: "no matter how 'necessary' or 'proper' an Act of Congress may be to its objective, Congress lacks authority to legislate if the objective is anything other than 'carrying into Execution' one or more of the Federal Gov-

ernment's enumerated powers. Art. I, § 8, cl. 18." 130 S. Ct. at 1972 (Thomas, J., dissenting, joined by Scalia, J.).

Similarly, in *Gonzales* v. *Raich*, this Court viewed the regulation of locally grown marijuana as a necessary means of enforcing the ban on interstate sales "[g]iven the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, * * * and concerns about diversion into illicit channels." 545 U.S. at 22; *see also id.* at 38 (Scalia, J. concurring in the judgment) ("the power to enact laws enabling effective regulation of interstate commerce can only be exercised in conjunction with congressional regulation of an interstate market, and it extends only to those measures necessary to make the interstate regulation effective").

Were the Necessary and Proper Clause to be read as the government suggests, the limitation imposed by the "for carrying into Execution" qualifier would be rendered meaningless. Congress may have any number of policy goals and desired outcomes from its exercise of its enumerated powers. The specification of congressional powers does not limit such policy goals, they limit the powers of Congress – the means by which Congress may act in pursuit of whatever goals it deems desirable. Similarly, the goals Congress may have do not delineate its powers. A perfectly valid goal may, nonetheless, be pursued by means that lie beyond Congress's powers, and a foolish goal may be pursued through concededly legitimate means. Conflating the "end" of exercising constitutional power with the goals of such exercise

simply allows the ends to be whatever Congress can imagine or desire.

In this case, for example, Congress desires all persons to have healthcare at an affordable price. If that is the legitimate "end" according to the government, then nothing that furthers that end would be beyond congressional power.[14] The government's claim that it is only exercising this power as part of a larger scheme also utilizing the commerce power to pursue its policy goals is no limitation on the breadth of its interpretation. There is no conceivable goal that could not be pursued in part by one or more of the enumerated powers. Yet under the government's view, once an initial use of such powers has been made, all other powers immediately follow in furtherance of the same policy goal.

The government's sweeping conception of what it means to "carry[] into Execution" Congress's enumerated powers would have other disturbing consequences beyond its application to the commerce power. Insofar as "carrying into Execution" is read to mean achieving the desired outcomes or "ends" of some otherwise valid exercise of an enumerated power, the implicit limits in many other enumerated powers would effectively be eliminated. For example, Congress's power to "provide for the * * * General Welfare of the United States," Art. I, sec. 8, cl. 1, may be exercised with an unlimited number and variety of

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[14] According to the government, the word "necessary" imposes no meaningful check, and the word "proper" at best incorporates federalism notions that are derived from the Tenth Amendment and the structure of the Constitution. They would provide no independent limits on Congressional power.

goals. But if merely spending money on a particular endeavor was insufficient to reach the desired result – educating the young, assisting battered women – then the petitioners' construction of the Necessary and Proper Clause would allow virtually *any* supplemental means of accomplishing such "ends." Similarly Congress's Power to "promote the Progress of Science and the useful Arts," Art. I, sec. 8, cl. 8, would no longer be limited to granting exclusive rights for limited times. Rather, if legislation granting exclusive rights to writings and discoveries were insufficient to promote progress in the arts and sciences, Congress could adopt whatever further mandates beyond the enumerated powers that it deemed necessary to achieve its end results and policy goals. It could compel people to become writers or inventors. It could compel people to buy writings and discoveries. The authority would seem to be limitless.

Even beyond execution of Congress's enumerated powers, the open-ended construction petitioners advocate for the Necessary and Proper Clause would implicitly expand the analogous "executive Power" of the President. Art. II, sec. 1, cl. 1. If "carrying into Execution" means achieving desirable outcomes from, rather than implementing, valid laws, then the President's power to "take Care that the Laws be faithfully executed," Art. II, sec. 3, could be read as equally broad, granting him extensive authority to act in furtherance of broad Congressional goals far beyond the mere implementation and enforcement of the law.

The above examples may seem absurd, but they are the straightforward implications of the petition-

ers' sweeping construction of the Necessary and Proper Clause.

A correct construction of that Clause would instead look to whether an exercise of an enumerated power requires something further in order to be operative. Thus, there is no doubt that when enacting an actual regulation of commerce, Congress has the power to establish penalties for non-compliance with that regulation, may require reporting and other measures to demonstrate compliance, and may hire persons to monitor and enforce compliance with those regulations. Those further powers indeed carry into execution the underlying power to regulate insofar as an unenforced regulation is effectively no regulation at all. But the power to make an exercise of Congressional authority operative is vastly different than the power to do anything necessary to achieve a desirable result. Congress routinely enacts undesirable or misguided regulations having all sorts of adverse effects, whether anticipated or not. The notion that Congress could thus bootstrap from its own policy failures into unlimited power to correct the consequences of such failures is unlimited and unthinkable.

CONCLUSION

For the reasons above, this Court should affirm the decision below on the unconstitutionality of the Individual Mandate.

Respectfully submitted,

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