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Senator Patrick Leahy
Chairman, U.S. Senate Committee on the Judiciary
433 Russell Senate Bldg
United States Senate
Washington, DC 20510

Re: "The Constitutionality of the Affordable Care Act"

Dear Senator Leahy:

This letter is in response to questions from Senator Durbin.

1. Do you agree that health care services are a form of interstate commerce that can be regulated by Congress?

Yes.

The United States Constitution empowers Congress to "make all Laws which shall be necessary and proper" to "regulate Commerce . . . among the several States." U.S. Const. art. I § 8, cl. 3. The Commerce Clause power includes the authority to "regulate those activities having a substantial relation to interstate commerce, . . . *i.e.*, those activities that substantially affect interstate commerce." *United States v. Lopez,* 514 U.S. 549, 558–59 (1995) (internal citations

omitted). Congress's broad commerce power is also rooted in the Necessary and Proper Clause. That clause authorizes the federal government to enact regulations that, while not within the specifically enumerated powers of the federal government, are nonetheless "'necessary and proper for carrying into Execution' the powers 'vested by' the 'Constitution in the Government of the United States.'" *United States v. Comstock*, 130 S.Ct. 1949, 1954 (2010) (quoting U.S. Const. art. I, § 8, cl. 18). In other words, the Necessary and Proper Clause permits Congress to enact regulations that are necessary or convenient to the regulation of commerce. In *Comstock*, the U.S. Supreme Court recently explained that the Necessary and Proper Clause provides federal regulatory authority where "the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power or under other powers that the Constitution grants Congress the authority to implement." *Id.* at 1957.

Health insurance and health care are both economic activities in interstate commerce that are indisputably within Congress's Commerce Clause power to regulate. Seventeen percent of the United States economy is devoted to health care. The Patient Protection and Affordable Care Act (ACA) § 1501(a)(2)(B). More than 11 million people work in the U.S. health care industry.[1] The federal government has for decades been deeply involved in healthcare regulation, including, among other programs Medicare, Medicaid, and CHIP. As the Supreme Court recently recognized, such a longstanding history helps to illustrate "the reasonableness of the relation between the new statute and pre-existing federal interests." *Comstock*, 130 S. Ct. at 1958. There

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[1] Kaiser Family Foundation, *Total Health Care Employment, 2009, available at* http://www.statehealthfacts.org/comparemaptable.jsp?ind=445&cat=8 (last visited Jan. 11, 2011).

can be no dispute that creating an affordable and accessible health insurance market is a legitimate Congressional goal, and one well within the scope of its Commerce Clause authority.

2. Does paying for health care services constitute activity?

Yes.

Congress may regulate three broad categories of activity under its commerce power:

> First, Congress may regulate the use of the channels of interstate commerce. Second, Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities. Third, Congress' commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce, *i.e.,* those activities that substantially affect interstate commerce.

Lopez, 514 U.S. at 558-559 (citations omitted).

The Supreme Court has long recognized that *de minimus* individual activities can be regulated under the third category—those that substantially affect interstate commerce.

For example, in *Wickard v. Filburn*, the Court upheld the federal power to regulate small amounts of wheat grown for home consumption. 317 U.S. 111, 128 (1942). The Court concluded that an activity will be deemed to have a "substantial effect" on interstate commerce if the activity, when aggregated with the similar activity of many others similarly situated, will substantially affect interstate commerce. *Id.*

Likewise, in *Gonzales v. Raich*, the Court upheld the federal power to prohibit the wholly intrastate cultivation and possession of small amounts of marijuana for medical purposes, despite express state policy to the contrary. 545 U.S. 1, 31-32 (2005). The *Raich* Court considered marijuana cultivation to be "economic activity" that could be aggregated to evaluate whether Congress had a rational basis to find a substantial effect on interstate commerce. *Raich* also makes clear that Congress may "regulate activities that form part of a larger regulation of economic activity." *Id.* at 24. Even if an activity is "'local and though it may not be regarded as commerce, it may still, *whatever its nature*, be reached by Congress if it exerts a substantial economic effect on interstate commerce.'" *Id.* at 17 (quoting *Wickard*, 317 U.S. at 128) (emphasis added).

Under *Wickard* and *Raich*, paying for health care is certainly an activity. It did not matter that the farmer in *Wickard* and the marijuana grower in *Raich* did not want to participate in the market; their actions were still deemed as activities that were part of the broader regulatory scheme. Similar to those *de minimus* individual activities, decisions regarding how to pay for health care services—including, in particular, decisions to forgo coverage and to pay later or, if

need be, to depend on free care—are activities, which have a substantial effect on the interstate health care market, as explained below.

3. In the Affordable Care Act Congress pursued the goal of making health care more affordable and more accessible to Americans, and did so by reforming the way that people pay for the health care that every American uses. Congress incentivized people to pay for their health care in the way that works best for the overall system - through the purchase of insurance that spreads risk - instead of paying in ways that strain the system or relying on others to bear their costs. **Did Congress have a rational basis to conclude that the way individuals pay for their health care has an enormous aggregate effect on Congress' efforts to make health care services affordable and accessible?**

Yes.

The Commerce Clause empowers Congress to regulate direct and aggregate effects of interstate commerce, as the Supreme Court recognized in *Raich* and in *Wickard*. *See Raich*, 545 U.S. at 16–17; *Wickard*, 317 U.S. at 127–28. Applying this principle, Congress certainly had a rational basis for reaching the conclusion that the way individuals pay for their health care has an enormous aggregate effect on Congress's efforts to make health care services affordable and accessible. In the aggregate, the decisions regarding how to pay for health care services have a powerful impact on the interstate health insurance and health care markets. Providing care to the uninsured has an especially adverse impact as those costs are passed on to everyone else through

higher premiums—on average, over $1,000 a year—and higher health care costs. ACA § 1501(a)(2)(F).

Uninsured individuals are not outside the interstate health care marketplace. They still participate in the marketplace because they seek medical attention within the health care system once they get sick. Two thirds of that medical care cost are passed on to other public and private actors in the interstate health care and health insurance system, including the state and federal governments, multi-state private insurance companies, and large multi-state employers. It is generally agreed that the cost for uncompensated care is substantial—billions of dollars each year.[2]

To illustrate how this impacts a single state, experts estimate that privately insured Oregonians pay a so-called $225 "hidden tax"—accounting for approximately 9% of a commercial premium—to cover the costs of the nearly 22% of the state who are uninsured and who are often unable to pay their medical bills.[3] Likewise, Oregon hospitals spent a combined $1.1 billion—an average 7.8% of gross patient revenue—on uncompensated care in 2009.[4] To

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[2] *See, e.g.*, Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. Med. & Ethics 397, 402 (2004); Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage? California's Recent Failed Experiment*, 18 S. Cal. Interdisc. L.J. 485, 499 (2009).

[3] K. John McConnell & Neal Wallace, *Oregon's Cost-Shift: The Effect of Public Insurance Coverage on Uncompensated Care* 3-4, *available at* http://www.oregon.gov/OHPPR/docs/OR_Uncom_Care-McConnell.pdf?ga=t (last accessed Jan. 25, 2011).

[4] Oregon Health Policy and Research, *Financial Data, 2009* (Dec. 7, 2010) *available at* http://www.oregon.gov/OHPPR/RSCH/docs/Hospital_Financials/2009_Margins_FINAL_120710.xls (last accessed Jan. 25, 2011).

put this number in perspective, Oregon hospitals had a combined net income of $255 million in 2009.[5]

The cost of the uncompensated care provided to the uninsured is magnified by the fact that the uninsured frequently delay seeking care. By the time they are treated, their medical problems are often more costly to treat than they would have been had they sought care earlier.[6] Furthermore, because emergency rooms are required by federal law to screen everybody who walks through their doors and to provide stabilizing treatment to those with an emergency medical condition, much of the care for the uninsured is delivered in this costly and inefficient setting. Indeed, treatment in an emergency room costs approximately three times as much as a visit to a primary care physician, at a cost of approximately $4.4 billion across the United States.[7]

In addition to the direct impact on the health care and health insurance systems, individuals who choose to forgo insurance affect the national economy in other ways, including

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[5] *Id.*

[6] *Hearings to Examine Health Care Access and Affordability and Its Impact on the Economy: Before the Subcomm. on Labor, Health and Human Services, Education, and Related Agencies of the S. Comm. on Appropriations*, 108th Cong. (2003) (testimony of Jack Hadley, Urban Institute), *available at* http://ftp.resource.org/gpo.gov/hearings/108s/89058.txt (last visited Jan. 19, 2011).

[7] California Association of Health Plans, *10 Factors Driving Costs for California's Hospitals* at 3 (Nov. 2010), *available at* http://www.calhealthplans.org/documents/IssueBriefHospitalCostDriversNovember2010.pdf (last accessed Jan. 13, 2011); *see also* USC Center for Health Financing, Policy, and Management, *Marginal Costs of Emergency Department Outpatient Visits: An update using California data* (Nov. 2005) *available at* www.usc.edu/schools/sppd/research/healthresearch/images/pdf_reportspapers/multivariate_cost_paper_v5.pdf (last accessed Jan. 13, 2011).

lost productivity due to poor health and personal bankruptcies due to health care costs, and some of the limited health care resources are shifted to emergency departments, rather than to preventative care.[8] Congress found that the national economy "loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured." ACA § 1501(a)(2)(E)

With these wide-ranging effects stemming from the way individuals pay for their health care, Congress had a rational basis to conclude that those actions have an enormous aggregate effect on efforts to make health care services affordable and accessible.

Sincerely,

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[8]Kaiser Family Foundation, *Hospital Emergency Room Visits per 1,000 Population, 1999, available at* http://www.statehealthfacts.kff.org/comparetrend.jsp?yr=6&sub=94&cat=8&ind=388&typ=1&sort=a&srgn=1 (last visited Jan. 12, 2011). From 1999 to 2008, emergency room visits rose from 365 to 404 per 1,000 population as uninsured rates increased.