State of Connecticut

RICHARD BLUMENTHAL
ATTORNEY GENERAL

Hartford
June 17, 2010

The Honorable John McKinney
Senate Minority Leader

The Honorable Andrew Roraback
The Honorable Len Fasano
The Honorable Tony Guglielmo
The Honorable John A. Kissel
The Honorable Sam S.F. Caligiuri
The Honorable Dan Debicella
The Honorable Robert Kane
The Honorable Toni Boucher
The Honorable L. Scott Frantz
The Honorable Michael McLachlan
The Honorable Kevin Witkos
State Senators

Senate Republican Offices
State Capitol
Hartford, Connecticut 06106

Dear Senators:

I received your letter of March 23, 2010 asking me to initiate legal action challenging the constitutionality of the recently enacted Patient Protection and Affordable Care Act ("the Act"), which seeks to expand health care to approximately 30 million uninsured Americans and restrict abusive health insurance practices that limit coverage. After extensive legal research and a careful balancing of the costs and potential benefits to Connecticut, I conclude that a lawsuit challenging the Act would have virtually no chance of success -- and may actually harm the State.

The Act is likely to be found constitutional by the courts -- and, equally important, our state is in a different practical and fiscal position from states challenging the Act.

I note at the outset that Governor M. Jodi Rell has not asked me to bring a legal action challenging the Act. In fact, on April 9, 2010, the Governor announced that she is formally seeking approval from the federal government to transfer 45,000 current recipients of a state-funded medical program into the Medicaid program pursuant to the Act, a change that will save

Connecticut at least $53 million over the next 15 months alone. In light of these savings, filing a lawsuit to undermine the Act could be costly to the State.

Three practical considerations strongly argue against litigation challenging the Act, which itself would invoke scarce public resources. First, Connecticut and its residents stand to realize important benefits from the Act, including expanded access to quality affordable health care, the prevention of unfair insurance practices, and the potential to obtain a grant to preserve and expand the University of Connecticut Health Center. *See* Act § 10502. It would be rash and presumptuous to block the Act from taking effect without a clear understanding of its overall effect on Connecticut, especially since many of the challenged provisions will not take effect for years.

Second, it remains doubtful that the Act will impose on Connecticut the kinds of far-reaching fiscal harms alleged in other states' lawsuits. Those lawsuits assert that the Act will place new burdens on the litigating states' existing Medicaid programs by expanding eligibility criteria, and that it will require the costly creation and administration of Health Care Exchanges. States with existing health insurance exchanges and broad Medicaid coverage -- such as Connecticut -- stand to benefit from the Act's provisions more than states with no exchanges and narrower coverage.

Connecticut's existing program to provide health care access to its citizens, both in its Medicaid and other programs, is among the most comprehensive in the nation. Connecticut already administers a Health Care Exchange for clients of HUSKY A, HUSKY B and Charter Oak. The Act provides for nearly full federal funding for expanded Medicaid populations, rather than the current 50-50 division between federal and state funding. As you may know, various state agencies are currently assessing the Act's estimated fiscal impact on Connecticut's budget.

As demonstrated by Governor Rell's announcement of at least $53 million in savings to the SAGA medical program in the next year alone, the requirement to expand certain Medicaid populations will actually significantly benefit -- not harm -- the State. According to the announcement, the SAGA medical program is currently 100% funded by the State, but once the recipients are transferred to the Medicaid program under provisions of the Act, 60% of the cost of their care will be reimbursed by the federal government, resulting in substantial ongoing savings to the State. In light of these significant savings, and others that may be identified, joining the lawsuit filed by states whose health care programs may be vastly different from those in Connecticut would be fiscally imprudent.

Third, joining other states' litigation efforts will require significant expenditures of state resources, but will provide Connecticut with no practical benefits. Even in the unlikely event that

claims asserted by other states were to succeed, any relief and conclusions as to the Act's constitutionality would apply with equal force to Connecticut, *at no expense to our taxpayers*.

The thrust of these pending legal challenges by other state attorneys general is that the Act -- and, in particular, the individual mandate to purchase health insurance -- exceeds congressional power. Under clear and longstanding principles of constitutional law set forth by the United States Supreme Court, I believe that the Act falls well within Congress' power and is therefore constitutional. [1]

The Constitution vests Congress with broad authority to enact legislation to regulate interstate commerce, to establish and collect taxes for the general welfare, and to enact laws that are necessary and proper to effectuate proper federal legislative purposes. U.S. Const. art I, § 8. There is no support in relevant Supreme Court or Court of Appeals caselaw for a claim that the Act as a whole, or its health insurance mandate in particular, is an unconstitutional exercise of congressional authority.

The so-called individual insurance mandate requires most individuals to have health insurance beginning in 2014, with subsidies provided to assist those who cannot afford the premium.[2] A phased-in tax penalty will be imposed on those who decide not to carry such insurance. This tax appears to fall squarely within Congress's power under the General Welfare Clause "to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defence and general welfare of the United States." U.S. Const. art. I, § 8. It is well established that Congress may impose taxes to promote the general welfare, *Helvering v. Davis*, 301 U.S. 619 (1937) (upholding the social security tax), which general welfare clearly includes the provision of health benefits and access to health care.

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[1] Only one case has directly considered the constitutionality of a government requirement to purchase health insurance, and in that case the requirement was found constitutional. Specifically, in *Fountas v. Comm'r of Revenue*, 2010 Mass. App. LEXIS 223 (March 5, 2010), the Appeals Court of Massachusetts affirmed the trial court's decision decisively rejecting arguments that Massachusetts' individual health insurance mandate violated the Constitution's Fifth or Eighth Amendments, constituted a bill of attainder, or unconstitutionally impaired the right of contract.

[2] Religious objectors, illegal aliens, and prison inmates are excepted from the individual mandate.

While one might object to this mandate on philosophical or policy grounds, the legal analysis to determine its constitutionality requires only that Congress has reasonably concluded that the provisions of the Act promote the general welfare. *Helvering* 301 U.S. at 643-45. The Act sets forth detailed congressional findings justifying the mandate as, among other things, necessary to increase access to health care and lower health costs in general. Act, § 1501(a). These conclusions are entitled to very substantial judicial deference under applicable Supreme Court precedent, *see Bowen v. Gilliard*, 483 U.S. 587, 598 (1987), and almost certainly will be deemed sufficient by a court to justify the mandate under the General Welfare Clause.[3]

Further, even if this Act were found to exceed Congress' authority under its taxing power, it certainly falls well within its powers under the commerce clause. Article I, § 8 of the Constitution gives Congress the authority to "regulate commerce . . . among the several states." There is no support in caselaw for the conclusion that Congress exceeded its commerce clause authority in passing the Act. Indeed, a conclusion that the Act violates the commerce clause would require a reversal of over 70 years of settled commerce clause jurisprudence and doctrine extending back through the creation of Medicare, Social Security and Medicaid and countless other vital and popular federal programs that have been the law of the land for decades.

Since the 1940s, the Supreme Court has recognized that Congress has broad authority to regulate interstate commerce. *See e.g., United States v. Darby*, 312 U.S. 100 (1941) (upholding

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[3] I also find no merit to the argument that the phased-in tax penalty is an unconstitutional "direct" tax. *See* U.S. Const. art I, § 9. Only three taxes have ever been held to be "direct" taxes: (1) a capitation, or poll, tax on the person, (2) a tax upon real property, and (3) a tax upon personal property. *See Fernandez v. Wiener*, 326 U.S. 340, 352 (1945) ("Congress may tax real estate or chattels if the tax is apportioned"); *Bromley v. McCaughn*, 280 U.S. 124, 136 (1929) (holding that direct taxes are generally laid upon one's "general ownership of property"); *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 637 (1895); *Murphy v. IRS*, 493 F.3d 170, 181 (D.C. Cir. 2007); *see also Hylton v. U.S.*, 3 U.S. 191 (1796). Here, the Act simply is not a capitation tax, a tax imposed directly on the general population. In fact, very few people will likely be subject to the tax at all, as most Americans have health insurance, millions more will acquire it under the Act, and substantial numbers will receive subsidies from the federal government to pay the premium. Instead, the Act imposes an indirect tax, which applies only to unexempted individuals who decide not to carry health insurance, and only for the period they remain uninsured. Such a tax is squarely within Congress' broad taxing authority under the Constitution.

wage and hour regulation); *Wickard v. Filburn*, 317 U.S. 111 (1942) (upholding market quotas for wheat as applied to a farmer producing only for personal consumption or local sale). As the Supreme Court more recently stated in *United States v. Lopez*, 514 U.S. 549, 560 (1995) (striking down a federal criminal statute prohibiting gun possession in school zones), "[w]here economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained."

The test of the constitutionality of legislation enacted under the interstate commerce clause is whether Congress could reasonably conclude that the economic activity it regulates has a substantial effect on interstate commerce. *Lopez*, 514 U.S. at 557. Under this test, the Supreme Court has sanctioned a wide array of congressional regulation, including regulation of both sales and consumption of goods and services. It is difficult to contemplate a court concluding that the health care industry is not a part of interstate commerce. In fact, there are few industries in our economy that more "substantially affect[] interstate commerce" than the health care industry.

In evaluating whether an activity has a substantial effect on interstate commerce, the focus is not on any one individual's activity, but on the cumulative effect of all such activities. *Gonzalez v. Raich*, 545 U.S. 1, 21-22 (2005) (upholding federal prohibition on possession and distribution of marijuana for medical use permitted by state law). Clearly, as Congress's findings in the Act document, the costs and burdens of providing health care to the approximately thirty million uninsured Americans who will receive coverage under the Act substantially affect interstate commerce. Commerce in goods and services across state lines relating to health care accounts for a significant portion of our national economy. Under this well-established understanding of congressional commerce clause authority, the health insurance mandate should easily pass constitutional muster and be upheld by a court.

Nor is there a constitutional basis to consider the failure to purchase insurance as "inactivity" beyond the reach of congressional regulation. First, it is unlikely that a court would deem an individual's decision not to purchase insurance as "inactivity," given the real and substantial effect on interstate commerce caused by the millions of uninsured individuals who still require health care. Indeed, a January 2010 report from the state Office of Health Care Access (OHCA) found that uninsured patients cost Connecticut hospitals approximately $215 million in fiscal year 2008 alone -- a 34% increase since fiscal year 2006. Nationwide, OHCA cited estimates putting the cost of providing uncompensated health care, the vast majority of which results from uninsured patients seeking treatment, at over $36 billion annually -- a tenfold increase since 1980.

Second, there is absolutely no support for a distinction between activity and inactivity in commerce clause jurisprudence. Congress has enacted laws mandating participation in economic activity, most notably in civil rights laws governing access by racial minorities to public accommodations, and these laws have been upheld under the commerce clause. For example, in *Katzenbach v. McClung*, 379 U.S. 294 (1964), the U.S. Supreme Court unanimously declared that failing to serve African-Americans at a restaurant catering primarily to local customers affected interstate commerce and therefore Congress could mandate that the restaurant provide such services. Additionally, in *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964), a unanimous Supreme Court held that failing to provide hotel accommodations to African-Americans in one state affects interstate commerce and therefore Congress could mandate that the hotel provide such services. In both cases, the Supreme Court upheld Congressional authority to regulate the refusal to engage in commerce by some in order to expand and protect participation in interstate commerce by others.

Similarly, failing to purchase health insurance does, and likely will continue to, result in significant impediments to the expansion of access to health care, increasing costs to individuals, insurance companies, and other participants in interstate commerce with respect to health care. As Congress expressly found, *see* Act § 1501(a)(2), requiring individuals to purchase health insurance will add millions of new customers to the rolls of our nation's health insurers, many of which are located here in Connecticut, thus obviously affecting interstate commerce. Congress reasonably concluded that adding these individuals to insurers' risk pools is essential to lowering health insurance premiums for all policy holders and to the survival of the insurers themselves because all insurers are now required to provide coverage for pre-existing conditions.

Nor is there merit to the argument that Congress lacks authority to require individuals to purchase a private product such as health insurance. Congress has broad authority to pass laws in furtherance of its constitutionally enumerated powers. Requiring the purchase of health insurance is clearly in furtherance of Congress' enumerated power to regulate interstate commerce.

In fact, the U.S. Supreme Court recently reaffirmed this bedrock principle, stating that "the Necessary and Proper Clause makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *United States v. Comstock*, 560 U.S. __ (2010) (quoting *McCulloch v. Maryland*, 4 Wheat. 316, 408 (1819)). In other words, if a law passed by Congress is "reasonably adapted" to the exercise of an enumerated Congressional power, that law will be upheld by the Supreme Court. Regardless of how one views the policy merits of the Act, requiring individuals to purchase health insurance is undoubtedly "reasonably

adapted" to further Congress' enumerated power to regulate the interstate commerce of health care and health insurance.

You also state in your letter that you believe the Act violates the Tenth Amendment by coercing states to expand their Medicaid programs and forcing state government to carry out the legislation. The thrust of the Tenth Amendment claim is that the federal legislation massively expands states' responsibilities and costs under Medicaid programs and that states will have no practical alternative but to comply with the federally imposed expansion. This is a theory advanced in the lawsuit brought by Florida and several other states challenging the Act. In my view, the Tenth Amendment does not provide a valid basis to bring a lawsuit on behalf of Connecticut.

Although the Tenth Amendment does preclude Congress from *directly* compelling state legislatures to enforce a federal regulatory program, *New York v. United States,* 505 U.S. 144, 140-41 (1992); *Hodel v. Virginia Surface Mining & Reclamation Ass'n, Inc.*, 452 U.S. 264, 288 (1981), it is clear that Congress can and often does, consistent with the Tenth Amendment, attach significant conditions on the receipt of federal funds, as long as such conditions are reasonably related to the funding program. *South Dakota v. Dole*, 483 U.S. 203, 206 (1987).

The states' argument in the litigation you reference is not that their continued participation in Medicaid is directly compelled--in fact, Medicaid participation by the states is purely voluntary--or that the Act's requirements are unrelated to federal Medicaid funding. Rather, their claim is that (1) it is a practical impossibility for a state to opt out at this juncture, and (2) the expansion will create an enormous burden--and one that the states could not have contemplated when they decided to initially opt into the program--that is tantamount to direct coercion of the states.

Similar arguments have been squarely rejected in prior cases. *See, e.g., West Virginia v. United States Department of Health and Human Services*, 289 F.3d 281 (4th Cir. 2002); *see also Kansas v. United States*, 214 F.3d 1202 (10th Cir. 2000) (noting that the coercion theory is "unclear, suspect and has little authority to support its application"); *Nevada v. Skinner*, 884 F.2d 445 (9th Cir. 1988) ("The coercion theory has been much discussed but infrequently applied in federal case law, and never in favor of the challenging party."); Kathleen Sullivan, Unconstitutional Conditions, 102 Harv. L. Rev. 1413 (1989) (arguing that coercion theory could never apply in spending clause context). In fact, no federal spending program has ever been struck down because the conditions attached to it were deemed unconstitutionally coercive.

For these reasons, I conclude that there is no valid legal basis to bring an action challenging the constitutionality of the Act.

I have demonstrated time and again that I am prepared to sue the federal government where valid claims exist and the interests of the State of Connecticut are threatened. For the reasons I have stated, litigation against the federal government under these circumstances would be unsuccessful and, as a practical matter, likely harmful to the State. This conclusion is compelled not by any consideration of my own views about the Act, but rather by clear judicial precedent and a balancing of the costs and benefits of litigation to the State of Connecticut.

Even if you support efforts to reform health care, as I do, you may still hope that changes are made to build on this good first step, and improve it. I personally believe, for example, that we must do more to contain costs and I was deeply disappointed in the Administration's decision to deny the Government the authority to negotiate prescription drug prices in Medicare. Clearly, however, such issues raise policy problems, not legal ones. They should be addressed through legislation, and not through the courts.

Very truly yours,

RICHARD BLUMENTHAL

RB/pas