

No. 11-398

In The Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN
SERVICES, ET AL., PETITIONERS

v.

STATE OF FLORIDA, ET AL.

*ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT*

**BRIEF FOR THE HEALTH FOUNDATION OF
GREATER CINCINNATI AS AMICUS CURIAE IN
SUPPORT OF NEITHER PARTY
(Minimum Coverage Issue)**

NATHALIE RAYMER
THE HEALTH FOUNDATION
OF GREATER CINCINNATI
3805 EDWARDS ROAD
CINCINNATI, OH 45209
(513) 458-6712

JAMES A. FELDMAN
Counsel of Record
5335 WISCONSIN AVE. N.W.
SUITE 440
WASHINGTON, D.C. 20015
(202) 730-1267
WEXFELD@GMAIL.COM

TABLE OF CONTENTS

	Page
Interest of the Amicus Curiae	1
Introduction and Summary of Argument	4
Argument.....	7
I. Uninsured status frequently results from financial need, not mere consumer prefer- ence	7
II. Uninsured status leads to limited access to health care and affects health	12
Conclusion	21

TABLE OF AUTHORITIES

Statutes:

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119	3
42 U.S.C. 18091(a)(2)(F)	6, 12

Miscellaneous:

Anne C. Beal, et al., <i>Closing the Divide: How Medical Homes Promote Equity in Health Care</i> , Commonwealth Fund pub.. No. 1035, at 9-10, 14-15, 20 (June 2007)	14
--	----

TABLE OF AUTHORITIES

(continued)

	Page
Families USA, <i>Hidden Health Tax: Americans Pay a Premium</i> (2009), http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf	12
74 Fed. Reg. 4199 (Jan. 23, 2009).....	8
Robert A. Fowler, et al., <i>An Official American Thoracic Society Systematic Review: The Association between Health Insurance Status and Access, Care Delivery, and Outcomes for Patients Who Are Critically Ill</i> , 181 Am. J. Respir. Crit. Care Med. 1003 (2010).....	17-18
Anthony Goudie and Adam C. Carle, <i>Ohio Study Shows that Insurance Coverage Is Critical for Children With Special Health Care Needs as They Transition to Adulthood</i> , 30 Health Affairs 2382 (2011)	18-21
Greater Cincinnati Community Health Status Survey, https://www.healthfoundation.org/data_publications/gcchss.html	2-3, 8-10, 12-15
Institute of Medicine, <i>Care without Coverage: Too Little, Too Late</i> (2002).....	16
Institute of Medicine, <i>America's Uninsured Crisis: Consequences for Health and Health Care</i> 5 (2009).....	16-17
Kentucky Health Issues Poll, https://www.healthfoundation.org/data_publications/khip.html	3, 11

TABLE OF AUTHORITIES
(continued)

	Page
J. Michael McWilliams, <i>Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications</i> , 87 <i>Milbank Quarterly</i> 443 (2009).....	17
Ohio Health Issues Poll, https://www.healthfoundation.org/data_publications/ohip.html	3, 10-11, 15
Thomas Rosenthal, <i>The Medical Home: Growing Evidence to Support a New Approach to Primary Care</i> , 21 <i>J. Am. Bd. Of Fam. Med.</i> 427, 428 (2008).....	14

In The Supreme Court of the United States

No. 11-398

DEPARTMENT OF HEALTH AND HUMAN
SERVICES, ET AL., PETITIONERS

v.

STATE OF FLORIDA, ET AL.

*ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT*

**BRIEF FOR THE HEALTH FOUNDATION OF
GREATER CINCINNATI AS AMICUS CURIAE
IN SUPPORT OF NEITHER PARTY
(Minimum Coverage Issue)**

INTEREST OF THE AMICUS CURIAE

The Health Foundation of Greater Cincinnati in its present form received its initial funding in 1998, when the Choicecare Corporaton, an HMO serving the Cincinnati area, was sold to Humana, Inc.¹ The

¹ The parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no counsel for a party nor any party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus

proceeds of the sale, approximately \$221 million, were invested, and the Foundation now spends 5% of its corpus annually, awarding about \$7.4 million each year through grants and direct charitable activities towards achieving its vision of helping the Greater Cincinnati region become one of the healthiest in the country. The Foundation operates in a 20-county region in Ohio, Indiana, and Kentucky.² The Foundation concentrates its grants in four areas (community primary care, school-age children's health care, substance use disorders, and severe mental illness), but it has also awarded grants in other areas as well in support of its mission.

In addition to funding the direct provision of health-care services, the Foundation has since its inception partnered with local universities and social scientists to conduct surveys and publish data on health and health care in the Cincinnati area and beyond. The Foundation initiated those efforts shortly after 1997, so that it could focus its resources in the areas of greatest need. Since then the Foundation has conducted many surveys, the largest of which is the Greater Cincinnati Community Health Status Survey, which is conducted every 5 years as a comprehensive assessment of regional health status,

or its counsel made a monetary contribution to its preparation or submission.

² The counties are Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren Counties in Ohio; Dearborn, Franklin, Ohio, Ripley, and Switzerland Counties in Indiana; and Boone, Bracken, Campbell, Gallatin, Grant, Kenton, and Pendleton Counties in Kentucky.

including physical, oral, vision, and mental health in the Foundation's 20-county service region. The Survey also includes assessments of insurance status and health-care access. In addition, the Foundation conducts a statewide Ohio Health Issues Poll and, together with the Foundation for a Healthy Kentucky, a statewide Kentucky Health Issues Poll once or twice a year to gather information and gauge views on health issues and policies at the State and federal levels. The resulting information is used to guide the Foundation's grant-making and assess its impact, and the information is widely shared with other regional health funders, health planners, health researchers, and policymakers.

Achieving the Foundation's goal of improved health care for individuals and families in its region depends on improving the availability of health insurance and health-care services to those who are currently underserved. In 2009 the Foundation launched a program focusing on educating the public on proposed reforms to the health-care and health-insurance systems. Since the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, was enacted on March 23, 2010, the Foundation has learned from its surveys that 65-72% of those surveyed do not have enough information to understand how the Act will affect them personally.³ In response, the Foundation has published 12 educa-

³ See https://www.healthfoundation.org/hp_docs/OHIPACADData.pdf (65% in Ohio); https://www.healthfoundation.org/hp_docs/KHIP%202010--Data%20for%20What%20Kentuckians%20Think%20about%20the%20ACA.pdf (72% in Kentucky).

tional pieces on the effects of the Act on health care and health insurance for individuals and families. Those publications are available online. See <http://reform.healthfoundation.org>.

The Foundation submits this brief in the hope that the data it is supplying – much of it data that the Foundation itself has gathered to help achieve its core mission of improving the health care of individuals and families in its region – will be of assistance to the Court in considering the issues in this case.

INTRODUCTION AND SUMMARY

Since its inception in 1998, the Foundation has learned a great deal, both directly from its data-gathering projects and indirectly through its experience as a funder of health-care services for the underserved. The Foundation does not take a position on the important constitutional questions presented by this case concerning the scope of Congress’s power under the Commerce Clause. There are, however, some issues with which the Foundation does have experience that touch upon some questions before the Court in this case.

In discussing the minimum coverage issue, the court of appeals in this case sharply distinguished between the health-care market and the health-insurance market, and it understood the mandate at issue in this case as requiring individuals who do not desire to do so to enter the latter, health-insurance market. In the court’s view, “[i]ndividuals subjected to th[e] economic mandate [to purchase health insurance] have not made a voluntary choice to enter

the stream of commerce, but instead are having that choice imposed upon them by the federal government.” Pet. App. 112a; see, *e.g.*, *id.* at 113a (“The question before us is whether Congress may regulate individuals outside the stream of commerce.”). The court stated that the government had “redefine[d] the regulated activity” from the purchase of health insurance to “the uninsured’s health-care *consumption* and attendant *cost-shifting*, or the *timing and method of payment* for such consumption,” and it rejected what it believed to be the government’s “redefin[ition].” *Id.* at 124a.

Embedded in the court of appeals’ discussion of these matters are two propositions: that uninsured individuals have made a voluntary decision to remain outside the health-insurance market, and that the health-insurance market is sharply distinct from the health-care market. The Foundation believes that both of those propositions, as a factual matter, are doubtful or mistaken.

First, as a factual matter, many or most uninsured individuals do not make a wholly voluntary choice not to purchase health insurance. Although a lack of health insurance may result from many factors, including exclusions commonly adopted by insurance companies, one important factor – especially for those with low income – is financial need. People with lower incomes are frequently unable to obtain health insurance, because it is too costly. When they do obtain insurance, it is less stable and assured than for others. For many people, the failure to obtain insurance is not a consumer preference, but the result of the inability to afford it.

Second, there are extraordinarily close ties between the health-insurance market and the health-care market – a market in which virtually everyone participates at one time or another. Congress itself recognized one of those ties: that the uninsured receive huge amounts of uncompensated care, whose cost is in turn passed on to those who do have insurance. See 42 U.S.C. 18091(2)(F). But another key tie is that, as a matter of fact, lack of insurance, especially for those with low income, leads to reduced access to needed health care, with potentially serious consequences for health. To be sure, the cost of health care can affect anyone. But studies show that those who are uninsured are more likely than others to do without drugs or physician care in order to pay for basic needs for food, clothing, and shelter. Those without insurance are also less likely than others to have a usual source of medical care – i.e., a clinic or doctor’s office where they usually go for medical help; having such a usual source of care is an important factor in actually obtaining needed medical care. More generally, both the Foundation’s studies and extensive national research have shown that lack of insurance tends to lead to lack of availability of needed health-care services, which in turn leads to poorer medical outcomes, including increased disease and worse.

ARGUMENT

The court of appeals in this case sharply distinguished between the health-insurance market (which it concluded Congress had no power to require individuals to enter) and the health-care market (which virtually everyone does enter). Individuals, however, generally *want* to enter the health-insurance market, but are frequently prevented from doing so by a variety of barriers, including the unaffordability of insurance. The reason they want insurance is the very close connection between the health-insurance market and the health-care market; the lack of insurance has a major effect on the access to and use of health-care services. This brief addresses those two points.

I. UNINSURED STATUS FREQUENTLY RESULTS FROM FINANCIAL NEED, NOT MERE CONSUMER PREFERENCE

There are many factors that make health insurance unavailable for individuals and families. Amicus AARP in its brief in this case has discussed some of the most significant ones, including employers' increased reluctance to provide (adequate) insurance, and denial or limitation of coverage and exceptional premium hikes for those with pre-existing conditions. See AARP Amicus Br. 8-14. These factors together exclude many people age 50-64 from the insurance market, and it is our experience that the same phenomena are often in play among the 18-64-year-old adults in our surveys. The Foundation's own studies, however, have supported the conclusion that poverty and near-poverty conditions themselves

also play a major role in making health insurance unaffordable or impossible to obtain.

1. The Greater Cincinnati Community Health Status Survey is conducted every five years for the Foundation by the Institute for Policy Research at the University of Cincinnati. The survey samples people from Ohio, Kentucky, and Indiana who live in the Foundation's service area. The most recent survey, in Fall 2010, asked respondents about their health insurance status.⁴ The responses suggest that for many people the failure to obtain health insurance is associated with financial need or exclusion from the market, not individual choice to remain uninsured and pay for health services as needed.

The survey asked respondents about both their health insurance status and their income with respect to the Federal Poverty Guidelines (FPG), which is a standard measure that is updated each year. At the time of the survey the FPG was \$10,830 for an individual and \$22,050 for a family of four. See 74 Fed. Reg. 4199 (Jan. 23, 2009). The survey results showed that those with lower incomes were more likely to be uninsured at any given time.

The results are reported for people between age 18 and 64 (*i.e.*, excluding children who are widely covered under the Children's Health Insurance Program and seniors almost universally covered under Medicare). For those whose incomes are below 100%

⁴ The methodology of the 2010 survey is fully described at https://www.healthfoundation.org/hp_docs/Overview%20of%20the%202010%20GCHSS.pdf

of the federal poverty level, 42% are currently uninsured. Of those whose incomes are between 100% and 200% of the FPG, 30% are uninsured. But of those whose incomes are more than 200% of the FPG, only 6% are uninsured.

The uninsured status of people with lower incomes would be even more stark were it not for Medicaid, the federal-state insurance for certain low-income people. For those whose incomes are below 100% of the FPG, 36% (more than half of these who have insurance) are covered by Medicaid (or Medicaid and Medicare), which does not require paying a premium. Among those whose incomes are between 100 and 200% of the FPG, 15% have Medicaid. See https://healthfoundation.org/hp_docs/GCCHSS%202010%20insurance%20status%20ages%2018-64%20data%20tables.pdf (tables showing original data from the Community Health Status Survey).

Not only are those with lower incomes more likely to be uninsured than others, but when they obtain health insurance, it is more unstable as well. Indeed, the survey showed that many individuals who are insured at a given time have been uninsured at some time in the past year. If those who have been uninsured within the last year are added to those who are currently uninsured, 50% of those with incomes below 100% of the FPG are uninsured, 41% of those between 100% and 200% of the FPG are uninsured, while only 11% of those with incomes over 200% of the FPG are uninsured. See *ibid.*

The following table summarizes these results:

**Uninsured Rates and Medicaid Coverage
by Poverty Level**

People age 18-64	Federal Poverty Level		
	Below 100%	100-200%	Over 200%
Uninsured now	43%	30%	6%
Uninsured now or in the past year	50%	41%	11%
Covered by Medicaid, or by Medi- caid and Medicare	36%	15%	3%

2. The 2011 statewide Ohio and Kentucky surveys report similar results.⁵ For example, in the Ohio Health Issues Poll, of those whose incomes are below the FPG, 37% are uninsured; for those between 100% and 200% of the FPG, 29% are unin-

⁵ The methodology of the Ohio and Kentucky Health Issues Polls are described at https://www.healthfoundation.org/hp_docs/OHIPoverview_FINL.pdf (Ohio); https://www.healthfoundation.org/hp_docs/KHIPoverview_FINL.pdf (Kentucky).

sured; but only 5% of those whose incomes are more than 200% of the FPG are uninsured. See https://www.healthfoundation.org/hp_docs/OHIP2011insurance.pdf. The following table summarizes these results:

Uninsured Rates by Poverty Level in Ohio

People age 18-64	Federal Poverty Level		
	Below 100%	100-200%	Over 200%
Uninsured	37%	29%	5%

Similarly, in the Kentucky Health Issues Poll, of those whose incomes are below 100% of the FPG, 55% are uninsured; for those between 100% and 200% of the FPG, 26% are uninsured; while only 14% of those whose incomes are more than 200% of the FPG are uninsured. See https://www.healthfoundation.org/hp_docs/KHIPUninsured_FINL_121211.pdf. The following table summarizes these results:

Uninsured Rates by Poverty Level in Kentucky

People age 18-64	Federal Poverty Level		
	Below 100%	100-200%	Over 200%
Uninsured	55%	26%	14%

Both the Ohio and Kentucky surveys showed that the insured status of those with lower incomes is also less stable; even if they do have insurance, they

are more likely than others to have been uninsured in the previous 12 months. These results strongly suggest that people with low incomes and those in poverty are much more likely to be uninsured — even taking Medicaid and similar programs into account — than those with higher incomes. For many of the uninsured, especially those with low income, the cost of insurance, not personal preference, is likely to be the reason for their uninsured status.

II. UNINSURED STATUS LEADS TO LIMITED ACCESS TO HEALTH CARE AND AFFECTS HEALTH

There is a key link between health insurance, access to the health-care marketplace for needed services, and, ultimately, the quality of one’s health itself. Congress itself made well-supported findings that the cost of uncompensated care for the uninsured is shifted to those who do have insurance, raising premiums by \$1,000 per year. 42 U.S.C. 18091(a)(2)(F); see Families USA, *Hidden Health Tax: Americans Pay a Premium* 2, 6 (2009). There is, however, another and more direct way in which the health-insurance and health-care markets are tied together. Substantial data gathered in the Foundation’s surveys, as well as data from many other studies, demonstrate that, notwithstanding that the uninsured do receive some uncompensated care, the uninsured have less access to health care — with likely serious effects on their health itself.

1. In the Fall 2010 Greater Cincinnati Community Health Status Survey, respondents were asked: “During the last year, did any household member not receive a doctor’s care [prescription medications] be-

cause the household needed the money to buy food, clothing, or pay for housing?” Those who were uninsured went without needed health care at a much higher rate than those with insurance. Thus, 11% of the insured but 40% of the uninsured had to go without a doctor’s care because they needed the money for basic living expenses. Similarly, 10% of the insured, but 31% of the uninsured had to go without prescription medications for the same reason. See https://www.healthfoundation.org/hp_docs/GCCHSS%202010%20Going%20without%20care%20data%20tables.pdf. Those who do not have insurance must go without needed medical services at a far higher rate than those with insurance.

The following chart summarizes these results:

Going Without Because the Household Needed the Money for Food, Clothing, or Housing

All Adults	Insured	Uninsured
Went without a doctor’s care in the past 12 months	11%	40%
Went without prescription medications in the past 12 months	10%	31%

2. Other data gathered by the Foundation support the conclusion that those without insurance have less access to health care and poorer health

outcomes. The Fall 2010 Greater Cincinnati Community Health Status Survey inquired whether respondents had a usual source of care. They were asked: “Is there one particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?” It is the Foundation’s belief, supported by extensive outside studies, that having a usual source of care is an important factor in obtaining needed medical care and achieving sound medical outcomes. See, e.g., Anne C. Beal, et al., *Closing the Divide: How Medical Homes Promote Equity in Health Care*, Commonwealth Fund pub.. No. 1035, at 9-10, 14-15, 20 (June 2007); Thomas Rosenthal, *The Medical Home: Growing Evidence to Support a New Approach to Primary Care*, 21 J. Am. Bd. Of Fam. Med. 427, 428 (2008) (Table 1) (“Patients who have a continuity relationship with a personal care physician have better health process measures and outcomes.”).

The Survey results showed that those who did not have health insurance were much less likely to have a usual source of care. Among those who were insured and whose type of insurance was known, between 87% and 96% had a usual source of care.⁶ But among those who were uninsured, only 62% had a usual source of care. See https://www.healthfoundation.org/hp_docs/GCCHSS%202010%20%20medical%20home%20data%20tables.pdf. Even that

⁶ A small number (ten) of respondents were listed as “Insured - Unknown,” suggesting incomplete data. Of those, 66.9% had a medical home and .7% were unsure.

percentage includes people who identified a hospital emergency room or an urgent care center as their usual source of care; if the survey had excluded those less-stable sources of care, the proportion of uninsured people with a usual source of care would have been substantially lower.

3. The results of the 2011 Ohio Health Issues Poll also showed a consistent relationship between individuals' ratings of their general health and insurance; as self-ratings of health quality declined, the likelihood of being uninsured increased. Thus, of the insured in the survey, 55% reported that they were in excellent or very good health and 15% reported they were in fair or poor health. Of the uninsured, only 36% reported they were in excellent or very good health, while 26% reported they were in poor health. See https://www.healthfoundation.org/hp_docs/insurance.pdf. These results too are consistent with the proposition that those without health insurance generally have poorer health outcomes than those who are insured. These data are summarized in the following table:

Self-Reported Health Status and Insurance

Health Status	Insured	Uninsured
Excellent or Very Good	55%	36%
Good	30%	38%
Fair or Poor	15%	26%

4. The link between lack of health insurance, less access to health care, and poorer health in general is

supported by numerous other studies. In 2002, the blue-ribbon Institute of Medicine published a comprehensive study, *Care without Coverage: Too Little, Too Late*. A committee of the Institute “select[ed] and evaluate[d] the best-designed research studies investigating the health of working-age adults with and without health insurance.” *Id.* at 5. The committee reviewed these studies and summarized its findings as follows:

Health insurance coverage is associated with better health outcomes for adults. It is also associated with having a regular source of care and with greater and more appropriate use of health services. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and the effective treatment of acute conditions such as traumatic injury and heart attacks. The ultimate result is improved health outcomes.

Id. at 6.

An updated 2009 review of new research for the Institute reached the similar conclusions that “new research evidence on the consequences of health insurance for children and adults is of higher quality and stronger than ever before,” and that “[t]his robust body of evidence demonstrates substantial health benefits of health insurance coverage.” *America’s Uninsured Crisis: Consequences for Health and Health Care* 5 (2009). In particular, children who have health insurance “have fewer avoidable hospitalizations, improved asthma outcomes, and fewer missed days of school,” while “[f]or adults, there are

serious harms and sometimes grave consequences to being without health insurance.” *Ibid.* “In sum, despite the availability of some safety net services, there is a chasm between health care needs and access to effective health care services for uninsured children and adults. Health insurance coverage in the United States is integral to individuals’ personal well-being and health.” *Id.* at 7.

An independent 2009 study done by Prof. J. Michael McWilliams of the Harvard Medical School carefully and exhaustively reviewed the evidence collected since the 2002 Institute of Medicine study had been published. See J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 *Milbank Quarterly* 443 (2009). The “new contributions” to the field had “consistently and robustly demonstrated the positive effects of health insurance coverage on the receipt of beneficial protective services and use of health care more generally, thereby establishing important mediating links in the causal pathway from health insurance to health outcomes.” *Id.* at 469. The study found that, although there had been “important strides in research quality” since the 2002 report, the new research had in the end “strengthened the evidence that uninsurance adversely affects health, thereby allowing conclusions to be more definitive.” *Id.* at 485.

Finally, a recent “official . . . systematic review” of the literature conducted by the American Thoracic Society examined the relation between uninsured status and outcomes for patients who were critically ill. Robert A. Fowler, et al., *An Official American*

Thoracic Society Systematic Review: The Association between Health Insurance Status and Access, Care Delivery, and Outcomes for Patients Who Are Critically Ill, 181 *Am. J. Respir. Crit. Care Med.* 1003 (2010). The study concluded that “the uninsured were much less likely than those who had insurance to receive critical care services.” *Id.* at 1006. Critically ill uninsured patients also “were more likely to have life support withdrawn . . . , less likely to have an invasive procedure . . . , or pulmonary artery catheterization . . . and more likely to experience discharge delays when medically ready to leave the hospital.” *Id.* at 1006-1007. Of perhaps greatest concern, uninsured critically ill patients “had a higher hospital mortality”; they “had a higher independent risk of death when compared with those with private/commercial insurance.” *Id.* at 1007.

5. The Foundation also partially funded a large study, the Ohio Family Health Survey. The analysis that was performed on the survey data reached similar conclusions about the availability of health care to the important subgroup of special-needs young adults. See Anthony Goudie and Adam C. Carle, *Ohio Study Shows that Insurance Coverage Is Critical for Children With Special Health Care Needs as They Transition to Adulthood*, 30 *Health Affairs* 2382 (2011). Special health-care needs arise from various chronic illnesses and disabling conditions that require medications, specialized health services, or a combination of both.

The study compared Ohio children (age 13-18) who had special health-care needs with young adults (age 19-26) who similarly had special health-care

needs. The children frequently were insured, because special health-insurance options are sometimes available for children. For example, school-age children are often eligible for their parents' employer-sponsored health insurance, though at the time of the study that eligibility ceased at age 19. In addition, children are frequently eligible for Medicaid, but that eligibility terminates at age 20 (aside from those who may remain on Medicaid due to disability). Thus, as children reach young adulthood and need their own insurance, it becomes much harder to get. That is especially true for those with special needs, because they have high rates of pre-existing health conditions that make them unattractive to insurers and sometimes unsuitable as employees (who may receive employer-sponsored group coverage). As a result, the survey showed that only 5% of children with special health-care needs were uninsured, as compared with 29% of special-needs young adults who were without insurance. See *id.* at 2385.

Among the report's conclusions was that "[b]eing uninsured and having special health care needs was directly associated with having a high rate of unmet health care needs" and "was also at least indirectly associated with an increased demand for emergency department visits and inpatient hospital stays." *Id.* at 2388. This can be seen in the following two tables. The first table, derived from Exhibit 2 in the study, *id.* at 2385, summarizes the unmet needs of the special-needs children and young-adults in the entire sample:

Unmet Needs of Insured and Uninsured Children and Young Adults Who Have Special Health-Care Needs

Unmet needs:	Children ages 13- 18	Young Adults, ages 19- 26
Prescription medications	8%	33%
Delayed or forgone care	11%	36%
Problems getting care	9%	20%

This can be compared with a further table, derived from Exhibit 3 in the study, *id.* at 2386, which summarizes the unmet needs of just the children and young adults who were uninsured:

Unmet Needs of Uninsured Children and Young Adults Who Have Special Health-Care Needs

Unmet needs:	Uninsured Children ages 13-18	Uninsured Young Adults, ages 19-26
Prescription medications	31%	64%
Delayed or forgone care	55%	69%
Problems getting care	15%	40%

In each category, the uninsured child or young adult has more unmet needs – often twice the level – as

the child or young adult with insurance. Moreover, considering both the children and the young adults in the study, those reporting unmet needs were more likely to have costly emergency department visits (31% and 45%) and hospital stays (12% and 23%). *Id.* at 2387 (percentages derived from Exhibit 5).

CONCLUSION

The lack of health insurance frequently results from financial need or lack of availability, not mere consumer preference. The health insurance and health care markets are closely tied, because uninsured status frequently leads to reduced access to health care and significantly affects health outcomes themselves.

Respectfully submitted.

NATHALIE RAYMER
THE HEALTH
FOUNDATION OF GREATER
CINCINNATI
3805 EDWARDS ROAD
CINCINNATI, OH 45209
(513) 458-6712

JAMES A. FELDMAN
Counsel of Record
5335 WISCONSIN AVE. NW
SUITE 440
WASHINGTON, D.C. 20015
(202) 730-1267
WEXFELD@GMAIL.COM

JANUARY 13, 2012