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Nos. 11-11021 & 11-11067

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees / Cross-Appellants,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,
Defendants-Appellants / Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF FLORIDA

BRIEF AMICI CURIAE OF ECONOMIC SCHOLARS IN SUPPORT OF DEFENDANTS-APPELLANTS[1]

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**U.S. COURT OF APPEALS FOR
THE ELEVENTH CIRCUIT**

State of Florida, et al.,
v.
United States Dep't of Health & Human Svcs., et al.

Nos. 11-11021 & 11-11067

CERTIFICATE OF INTERESTED PARTIES AND CORPORATE DISCLOSURE STATEMENTS

Pursuant to 11th Cir. R. 26.1-1, the undersigned counsel certifies that, to the best of his knowledge, the following persons, firms, and associations are the only ones that may have an interest in the outcome of this case:

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STATEMENT OF THE ISSUES

The *Amici* adopt the Statement of the Issues contained in the Brief of the Appellants. This Brief will address solely the first issue in that Statement.

SUMMARY OF ARGUMENT

Virtually all of us will at one time or another require medical care, whether we intend to or not. Thus, everyone is a participant in the health care market. The decision that we make as to how we will pay for the health care we will inevitably need-- *i.e.* whether to purchase health insurance or postpone payment to the future -- has enormous implications on the national economy. Section 1501 of the Affordable Care Act, which requires all who can it afford it to purchase a minimum level of health insurance or pay a penalty to the U.S. Treasury, is a measured and economically appropriate means of addressing the problems facing the health care market.

That market is characterized by five unique factors that are not present in other markets: the unavoidable need for medical care, the unpredictability of such need, the high cost of care, the inability of providers to refuse to provide care in emergency situations, and the very significant cost-shifting that underlies the way medical care is paid for in this country. Because of the high costs of medical care and the unpredictability of when we will need it, insurance is the way we typically pay for health care. In enacting Section 1501, Congress recognized these facts and

sought to spread health care costs among those that need, or will need, medical care.

The decision to forego insurance is not "inactivity," as the Court below believed, but an economic decision as to how individuals will pay for their inevitable need for health care -- *i.e.* their decision to purchase health insurance or put payment off to the future. That decision, which studies demonstrate is typically not inadvertent but made on a reasoned and conscious basis, has enormous implications for the national economy. Consequently, the decision to forego purchasing health insurance is not several steps removed from interstate commerce, as the Court below found, but directly and immediately affects an industry that represents more than sixteen percent of our gross domestic product. The Section lies well within established precedent under the Commerce and Necessary and Proper Clauses.

Further, upholding Congress' power to adopt Section 1501 will not vitiate the Constitutional framework of a federal government of limited delegated powers or usurp the police powers of the States. The economics of the health care market are unique, and the economics of none of the other markets discussed by the Court below or by the Appellees is characterized by the sharing of costs that characterizes the health care market. Section 1501 is a tailored response to a distinct market imperfection that does not exist in other markets. Affirming

Congress' power to act here will not open the floodgates and empower Congress to require individuals to purchase or use goods and services because Congress concludes it is good for them.

INTRODUCTION

The *Amici Curiae* submit this brief [3] in support of the Government and urge the Court to reverse the decision of the United States District Court for the Northern District of Florida[4] finding that Section 1501 of the Patient Protection and Affordable Care Act ("ACA" or "Act") exceeded Congress's power under the Commerce Clause.[5] That Section requires, with certain exceptions, that all Americans who can afford a minimum level of health insurance either purchase such coverage or pay a penalty to the United States Treasury.

INTEREST OF *AMICI CURIAE*

Amici Curiae are professors and scholars in economics who have taught, studied, and researched the economic forces operating in and affecting the health care and health insurance markets. The Economic Scholars include internationally

[3] Counsel for Appellants and for both the States, and for NFIB and the individual Appellees, have consented to Amici filing this brief. No counsel for any party authored this brief in whole or in part, nor did any party, person, or entity other than Amici and its counsel, make a monetary contribution to the preparation and submission of this brief. *See* Fed. R. App. P. 29(c)(5).

[4] *Florida ex rel. Bondi v. Dep't of Health & Human Servs.*, --- F. Supp. 2d ---, 2011 WL 285683, No. 3:10-cv-91-RV/EMT (N.D. Fla. Jan. 31, 2011).

[5] Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

recognized scholars in economics, including three Nobel laureates,[6] two recipients of the John Bates Clark Medal for the outstanding American economist aged 40 and under,[7] and former high-ranking economists in a number of former administrations. The *Amici* believe that reform of the health care system is essential to constraining the growth of health care spending and that broadly-based insurance coverage is essential to any reform of the health care system in this country.

This brief describes the unique economics of the health care industry and explains why there is no such thing as "inactivity" or non-participation in the health care market.[8] Virtually all Americans will, at some time during their life, require health care, either because of illness, accident, or the wear and tear of age. Given the extremely high costs of health care for all but the most routine treatments and procedures, the cost of medical care is beyond the means of all but the most wealthy Americans. Insurance is the means by which we pay for our

[6] The Nobel Laureates are Dr. Kenneth Arrow (1972), Dr. George Akerlof (2001), and Dr. Eric Maskin (2007).

[7] The winners of the John Bates Clark Medal are Dr. Susan Athey (2007) and Dr. Matthew Rabin (2001).

[8] *Amici* have filed this brief with appropriate modifications for the applicable facts in the following other cases challenging the constitutionality of Section 1501: *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010), *appeal docketed*, Nos. 11-1057 & 11-1058 (4th Cir. Jan. 20, 2011); *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010), *appeal docketed*, No. 10-2388 (6th Cir. Oct. 25, 2010); *Liberty Univ. v. Geithner*, --- F. Supp. 2d ---, 2010 WL 4860299, No. 6:10-cv-00015-nkm (W.D. Va. Nov. 30, 2010), *appeal docketed*, No. 10-2347 (4th Cir. Dec. 3, 2010).

health care, and the requirements of Section 1501 assure that all Americans who can afford it contribute to the costs of their own health care by maintaining reasonable insurance coverage. Without it, those costs will be borne by those who buy insurance or by the taxpayers. As Massachusetts Governor Romney noted when signing the Massachusetts equivalent of Section 1501:

> Some of my libertarian friends balk at what looks like an individual mandate. But remember, someone has to pay for the health care that must, by law, be provided: Either the individual pays or the taxpayers pay. A free ride on the government is not libertarian.[9]

Amici also show why confirming Congress' power to enact Section 1501 will not result in the vast expansion of federal power of concern to the court below. The health care market is characterized by five unique factors -- the unavoidable need for medical care; the unpredictability of such need; the high cost of care; the inability of providers to refuse to provide care in emergency situations; and the very significant cost-shifting that underlies the way medical care is paid for in this country -- which do not obtain in other markets. Without these factors, the need for provisions such as those adopted in Section 1501 is absent. Congress can fully address collective actions by individuals that affect interstate commerce through less intrusive requirements. However, reform of the health care and health care

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[9] Mitt Romney, *Health Care for Everyone? We Found A Way*, The Wall Street Journal, Apr. 11, 2006, p. A16, *available at* http://online.wsj.com/article/SB114472206077422547.html/mod=opinion_main_commentaries.

insurance markets is dependent on spreading the costs of health care across as much of the consuming public as possible. That requirement does not exist in any of the other markets identified by the District Court or the Appellees. Contrary to the District-Court's assertion, affirming Congress' power to adopt Section 1501 will not open the door to unfettered federal encroachment upon individual liberty or the police powers of the States.

ARGUMENT

The District Court held that the individual mandate to acquire health insurance under Section 1501 exceeds the permissible scope of federal power by requiring that individuals engage in a prescribed form of economic activity.[10] Notably, the Court found that Section 1501 exceeds the boundaries of congressional authority under the Commerce Clause by extending federal regulation beyond economic activity to reach inactivity.[11]

Rooted in this purported distinction between activity and inactivity, the Court asserted that upholding the constitutionality of the ACA will provide the legal foundation for creating expansive national power that a future Congress may use to regulate nearly anything.[12] Notwithstanding solid case law confirming the

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[10] *Florida ex rel. Bondi*, 2011 WL 285683, at *41.

[11] *See id.* at *22 ("It would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause.").

[12] *See id.* at *29 ("To now hold that Congress may regulate the so-called 'economic decision' to *not* purchase a product or service in anticipation of *future* consumption is … without logical limitation and far exceeds the existing legal boundaries

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breadth of congressional power to regulate when necessary and appropriate to achieve an objective within its powers under the Commerce Clause, the District Court concluded that Congress lacked the power to require individuals to purchase health insurance. It reached that conclusion on the grounds, *inter alia*, that Congress had never attempted to regulate inactivity under the Commerce Clause and that establishing a relationship between the failure to acquire insurance and interstate commerce required "piling 'inference on inference'".[13]

The fundamental flaw with the District Court's analysis of Section 1501 is that it relies on a false distinction between economic activity and inactivity.[14] Although the decision to forego insurance has the superficial appearance of inaction, it is, from an economic perspective, merely an act of choosing a preferred method for paying anticipated medical costs during a particular period of time. It is also an act that substantially affects the cost of health care for other individuals and the overall operation of the interstate health care and health insurance markets.

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established by Supreme Court precedent."); *see also Virginia ex rel. Cuccinelli*, 728 F. Supp. at 788 ("The unchecked expansion of congressional power to the limits suggested by the Minimum Essential Coverage Provision would invite unbridled exercise of federal police powers.")

[13] *Florida ex rel. Bondi*, 2011 WL 285683, at *27.

[14] We have not been able to find any express support for this distinction in a Supreme Court decision and none has been cited by Appellees or the District Court. To the extent address, precedent indicates that there is no such distinction. *Cf. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296 (1990) (Scalia, J., concurring)(When considering something from a legislative perspective, it should be the outcome that is important, as "the intelligent line does not fall between action and inaction.")

Section 1501 is a tailored response to these circumstances, assuring that all who can afford it bear a share of the medical expenses they will inevitably demand, rather than merely imposing the costs largely or entirely on others. Spreading the escalating costs of health care among all who will use it is essential to achieving Congress' legitimate goal of regulating those costs, which constitute more than one sixth of the nation's gross domestic product. Consequently, the underlying economics of the health care market clearly justify Congress' adoption of Section 1501.[15]

I. The Unique Economics of the Health Care Industry Make the Minimum Coverage Provision Necessary

Economists have long recognized that health care has unique characteristics not found in other markets. Indeed, health care violates almost all of the requirements for markets to yield first best outcomes (termed "Pareto optimality").[16] One requirement for market optimality is that people know what they need, and that they have full information about how to obtain it. In medical care, in contrast, need is unpredictable and information -- particularly about the costs of medical treatment -- is much less than complete. Second, optimality

[15] *See Liberty Univ. v. Geithner*, 2010 WL 4860299, at *15 ("Far from 'inactivity,' by choosing to forgo insurance, Plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now, through the purchase of insurance."); *see also Mead v. Holder*, --- F. Supp. 2d ---, 2011 WL 611139, Civ. No. 10-950 (GK), at *15-16 (D.D.C. Feb. 22, 2011); *Thomas More Law Center*, 720 F. Supp. 2d at 894.

[16] Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," American Economic Review, 53(5), December 1963, p. 941-973; N. Gregory Mankiw, Principles of Economics, 5th Edition, New York: South-Western, 2009.

requires that individuals' actions affect only themselves. This is again not true in medical care, where an individual's actions have effects far beyond themselves -- both directly (by spreading communicable diseases, for example) and indirectly (by not being insured and thus shifting costs to others, for example).

Optimality in a market also requires vigorous competition on the part of providers. Because of the uncertainty about medical care, however, we impose a variety of constraints on medical care providers, including licensing requirements and regulation of the provider-patient relationship. Structural factors in the markets for health care, such as the limited number of hospitals and primary care physicians, also are inconsistent with perfect competition. As a result of these market failures, economists do not approach the health care industry with anywhere near the deference to individual choice or the expectations of optimality that they do in other markets.

These market failures are the foundation for the field of health economics and have been an object of study for decades. The paper that launched the field nearly a half century ago notes that "[T]he failure of the market to insure against uncertainties has created many social institutions in which the usual assumptions of the market are to some extent contradicted. The medical profession is only one example, though in many respects an extreme one."[17] That remains true today.

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[17] Arrow, *supra* n.16, at 967.

Of particular relevance to this case, economists who have studied health care and health insurance for many decades have concluded that it is incorrect to say that people who do not purchase health insurance do not participate in or affect the markets for medical care and health insurance. Rather, all participate in the markets for medical services and necessarily affect the market for health insurance. This conclusion revolves around three observations:

A. *People cannot avoid medical care with certainty, or be sure that they can pay for the costs of care if uninsured.*

Everyone gets sick or suffers an injury at some point in life. When they do, they generally need medical care. Further, sickness, and especially injury, is often unforeseen. People need medical care because of accidents, because of life situations beyond their control (*e.g.*, cancer, a mental health emergency), because events turn out different from expected (*e.g.*, chronic care medications fail to stem a disease), or because of the normal aging process (*e.g.,* joint replacement, Alzheimer's disease, congestive heart failure). Thus, even if people do not intend to use medical care, they often use it anyway. According to tabulations from the Medical Expenditure Panel Study, the leading source of data on national medical spending, 57 percent of the 40 million people uninsured in all of 2007 used medical services that year.[18] By another metric, even the best risk adjustment

[18] Agency for Health Care Quality and Research, Medical Expenditure Panel Survey, Summary Data Tables, Table 1.

systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur;[19] the vast bulk of spending needs cannot be forecast in advance.

Moreover, because medical care is so expensive, essentially everyone must have some access to funds beyond their own resources in order to afford it. In 2007, the average person used $6,186 in personal health care services,[20] which is over 10 percent of the median family's income that year and over 20 percent of the median family's financial assets.[21] Even routine medical procedures, such as MRIs, CT scans, colonoscopies, mammograms, and childbirth, to name a few, cost more than many Americans can afford.

Those suffering from many common, but costly, medical problems spend substantially more. For example, medical costs in the year after a colorectal cancer diagnosis average $25,000, even before expensive new medications;[22] pancreatic cancer costs about $57,000;[23] and treatment of a heart attack for 90 days cost over

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[19] Ross Winkelman and Syed Mahmud, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment, Society of Actuaries, 2007.

[20] Center for Medicare and Medicaid Services, National Health Expenditure Accounts. Homes are not counted toward one's "financial assets."

[21] Brian K. Bucks, Arthur B. Kennickell, Traci L. Mach, and Kevin B. Moore, "Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances," Survey of Current Business, February 2009, A2-A56.

[22] K. Robin Yabroff, Elizabeth B. Lamont, Angela Mariotto, Joan L. Warren, Marie Topor, Angela Meekins, Martin L. Brown, "Costs of Care for Elderly Cancer Patients in the United States," Journal of the National Cancer Institute, 100(9), 2008, 630-641.

[23] *Id.*

$20,000 in 1998.[24] All told, ranking everyone on the basis of medical spending, including those who did not use any care, the costs for the top 1% of that distribution equaled $85,000 on average.[25] This amount is 46 percent above median family income and nearly three times the financial assets of the median family. Indeed, this amount -- $85,000 -- exceeds the total financial assets of all but the very well-to-do.[26] Thus, it is very difficult for anyone to commit to paying for medical care on their own, and only the exceptionally wealthy can even consider doing so.

The combination of the uncertainty of need and the high cost of care when needed highlights the fundamental distinction that health economists make between health insurance and medical care. Medical care is the set of services that make one healthier, or prevent deterioration in health. Health insurance is a mechanism for spreading the costs of that medical care across people or over time, from a period when the cost would be overwhelming to periods when costs are more manageable. The decision to regulate health insurance is not based on any normative view about the benefits of medical care for any particular person.

[24] David M. Cutler and Mark McClellan, "Is Technological Change in Medicine Worth It?", Health Affairs, 20(5), September/October 2001, 11-29.

[25] Kaiser Family Foundation, Trends in Health Care Costs and Spending, March 2009; Agency for Health Care Quality and Research, Medical Expenditure Panel Survey, Summary Data Tables, Table 1.

[26] Bucks et al., *supra,* n.21 at A27. This study reports that the median value of the direct and indirect stock holdings of all families with income below but the 90th percentage was $62,000 in 2007. Indirect stock holdings include pooled investment trusts, retirement accounts and other managed accounts.

B. *Other legislation mandates access to a minimum level of health care for all who seek it, even those who cannot pay.*

Existing federal legislation requires care to be provided to the very sick, even if they cannot pay for it. The Emergency Medical Treatment and Labor Act ("EMTALA")[27] mandates that hospitals that take Medicare, and virtually all do, stabilize patients who come to their emergency rooms with emergency conditions without regard to whether they can pay for the care they need. Long before EMTALA, most hospitals provided this charity care as part of their mission.[28] This tradition of assuring the availability of some minimal level of treatment to all Americans without regard to ability to pay reflects a collective decision that we are, as a Nation, generally unwilling to see others come to great harm for lack of access to medical care.

There are many other respects in which the special nature of health care justifies imposing unique restrictions on private actors in the health care system. Because medical care is not an ordinary commodity, physicians owe their patient a duty[29] and are not free to contract over the terms of treatment in the same manner

[27] 42 U.S.C. § 1395dd.

[28] Charles Rosenberg, The Care of Strangers: The Rise of America's Hospital System, Baltimore: Johns Hopkins, 1995; David Rosner, A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York 1885-1915, Oxford: Cambridge University Press, 1982; Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century, Baltimore: Johns Hopkins, 1999.

[29] *See* Jill R. Horwitz, *The Multiple Common Law Roots of Charitable Immunity: An Essay in Honor of Richard Epstein's Contributions to Tort Law,* J. Tort L., Jan. 2010, at 29-33.

as other buyers and sellers.[30] For example, medical care providers must ensure that their patients are informed before they give consent to their treatment. Additionally, physicians are bound under a common law duty not to abandon their patients once a physician-patient relationship is established. The physician has an obligation to provide care throughout an episode of illness and may not terminate the relationship unless certain restrictive conditions are met, including that either the patient fires the physician or the physician gives the patient sufficient notice and opportunity to find alternate, sufficient treatment. [31] These requirements for severing the physician-patient relationship apply even if the patient cannot pay for his care.[32]

These obligations to provide medical care without regard to ability to pay necessarily impose costs that must be borne by others, either through taxes or through cost shifting that increases the costs for those who are able to pay, whether personally or through insurance. Economists variously term these induced costs an

[30] *See, e.g., Tunkl v. Regents of Univ. of California*, 60 Cal. 2d 92, 383 P.2d 441 (1963) (finding that even though a patient may understand the significance of a contract releasing a hospital from potential liability in exchange for medical care, hospitals may not benefit from these exculpatory clauses because of the special way in which health care affects the public interest).

[31] *See, e.g., Saunders v. Lischkoff,* 137 Fla. 826, 836, 188 So. 815, 819 (1939) (noting that the obligation of continuing treatment can only be terminated "by the cessation of the necessity which gave rise to the relation of physician and patient, or by the discharge of the physician by the patient, or by the physician's withdrawing from the case, after giving the proper notice."). *Accord*, *e.g., Lewis v. Capalbo,* 280 A.D.2d 257, 820 N.Y.S.2d 455 (2001); *Magana v. Elie,* 108 Ill. App.3d 1028, 439 N.E.2d 1319 (1982).

[32] *See*, *e.g.*, *Ricks v. Budge*, 64 P.2d 208 (Utah 1937) (finding that the doctor did not give sufficient notice to allow his patient to procure other medical attention).

externality (a situation where one person's actions or inactions affects others), a free-rider problem (where people buy a good and leave the costs to others), or a Samaritan's dilemma (where people choose not to be prepared for emergencies, knowing that others will care for them if needed). Even basic economics textbooks stress that externalities require government intervention to improve the functioning of the market.[33]

C. *Whether one person buys health insurance has cost implications for everyone else.*

Economists universally recognize that the time dimension is a key part of individual decision-making. For most goods and services, the moment of purchase is different from the moment of consumption (purchase almost always precedes consumption). Thus, the decision to forgo insurance cannot be separated from the consequences of being without insurance, and no economic model treats them as separate. The consequences are three-fold. First, the decision not to purchase insurance may inevitably be followed by becoming ill, and thus using care financed by others. Second, people may forgo preventive care while uninsured (such as a mammogram or colonoscopy) and spend more later (for example, when diagnosed with advanced cancer). Third, people may only receive partial care

[33] N. Gregory Mankiw, *supra* n.16.

when they are uninsured and sick, and then use more care when they become insured.[34]

In each of these circumstances, being uninsured imposes costs on others. These consequences show -- in stark contrast to the District Court's opinion -- that the "mere status of being without health insurance" does have real and significant impacts on interstate commerce far different from an individual who lacks other types of insurance or is without other goods.[35] Because medical care is so expensive, particularly when people are very sick, and medical care providers are required to care for sick people, the cost of people choosing to be without coverage are necessarily shared with others. The medical care used by each uninsured person costs about $2,000 per year, on average. Only 35 to 38 percent of this total is paid for by the uninsured directly in out-of-pocket payments.[36]

The remainder is financed in several ways. Thirty-two percent of the total is paid for by providers charging higher prices to the insured, as providers "cost

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[34] The District Court was thus incorrect in its five-step analysis for when an uninsured individual would have a "substantial effect on interstate commerce." *See Florida ex rel. Bondi*, 2011 WL 285683, at *26. An uninsured person need not seek medical assistance at the time of a single complication to create current and future impacts on the interstate market.

[35] *Id.* (stating that those without health insurance have "*no impact whatsoever*" on interstate commerce, or at least no more than being without any other good or service).

[36] Agency for Health Care Quality and Research, Medical Expenditure Panel Survey, Summary Data Tables, Table 1; Jack Hadley, John Holahan, Teresa Coughlin and Dawn Miller**,** "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs, 27(5), 2008, w399-w415, *et al.*

shift"[37] from the uninsured to the insured. The total amount of cost shifting is over $40 billion per year, and the increase in private insurance premiums resulting from this cost shifting has been estimated at between 1.7 percent[38] and 8.4 percent.[39] Another 14 percent of the costs of the uninsured are paid for by government, through Medicare and Medicaid payments, and services used through the VA, TriCare (medical insurance for the military and their families), and workers' compensation. Higher government costs attributable to the uninsured are implicitly paid for by the insured as well, through increased taxes or reductions in other government services as money is spent on the uninsured. Finally, the remaining costs are generally either borne by the health-care providers or covered by philanthropic contributions to hospitals and other medical providers.

Moreover, even people who are able to avoid using medical care when they are without health insurance affect the amount paid by others, in two separate ways. First, when some, relatively healthier people, refrain from buying health insurance, that raises the premiums of the people who wish to purchase insurance, a phenomenon termed "adverse selection." Second, when people who were previously uninsured for a period of time do obtain coverage, they tend to consume more care and result in greater costs to the system.

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[37] Hadley, *et al.*, *supra* note 36.

[38] *Id.*

[39] Families USA, "Paying a Premium", Washington, D.C.: Families USA, July 2005.

This adverse selection causes the premiums for health insurance to increase as a result of a smaller and less healthy pool of insured persons. The increase in premium costs also causes additional people -- many of whom are healthy -- to opt out of the market, raising prices even higher. The end result of this process of individuals opting-out or waiting to purchase health insurance will be significantly lower coverage, and possibly an unraveling of the market as a whole, what is widely termed an adverse selection "death spiral."[40]

In most states, insurers attempt to counter adverse selection by discriminating against the ill, through denials of coverage or exclusion of pre-existing conditions. Yet, as noted, all of us are at risk for becoming ill and needing medical care. An insurance market that encourages insurers to exclude people when sick denies people a fundamental element of insurance, reducing the economic benefits of insurance substantially.

Unfortunately, simply removing these tools from the reach of insurance companies does not solve the problem; insurers react by raising prices for all market participants to guard themselves against losses from selling only to the sick. Several states have tried mandating coverage of individuals with pre-existing conditions, non-discrimination in insurance pricing, and other similar reforms of

[40] David M. Cutler and Sarah Reber, "Paying for Health Insurance: The Trade-off between Competition and Adverse Selection," Quarterly Journal of Economics, 113(2), 1998, 433-466.

their markets for individuals' policies, but without the equivalent of a minimum coverage requirement. All of these State experiments have failed and are among the most expensive states in which to buy non-group insurance.[41]

And, uninsured people have been shown to incur greater health care costs when they become insured, as a result of their having been uninsured. People who are uninsured often have delayed access to primary, preventive, and chronic care and thus become sicker over time.[42] When acute illness occurs, they may be insured through public or private insurance, thus increasing the amount that those programs spend. For example, Medicare beneficiaries who were uninsured prior to becoming eligible for Medicare used 51 percent more services than those who were insured prior to Medicare eligibility.[43] These costs are largely paid for by people who are insured, who pay higher taxes for Medicare when they are working, pay higher premiums for Part B coverage when they are enrolled in Medicare, or receive fewer government services because of the higher cost of Medicare.

[41] Jonathan Gruber and Sara Rosenbaum, "Buying Health Care, The Individual Mandate, and the Constitution," New England Journal of Medicine, 2010; 363:401-403.

[42] Committee on the Consequences of Uninsurance, Institute of Medicine, Health Insurance is a Family Matter 106 (2002).

[43] J. Michael McWilliams, Ellen Meara, Alan M. Zaslavsky, and John Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," New England Journal of Medicine 2007; 357:143-153.

The only economic solution to this dilemma is to ensure broad participation in insurance pools by all people. The minimum coverage requirement is one way to do this.

II. Upholding Section 1501 Will Not Give Congress Unfettered Power to Impose New Mandates on Individuals

A. *Health Care Characteristics Distinguish It From Other Markets.*

The unique characteristics of health care described in the preceding section also demonstrate why upholding the minimum coverage provision will not lead ineluctably to equivalent federal interventions in other markets. The combination of the unavoidable need for medical care; the unpredictability of such need; the high cost of care, which in many situations far outstrips an individual's or family's ability to pay; the fact that providers cannot refuse to provide care in emergency situations, and generally will not in many other situations; and the very significant cost-shifting that underlies the way medical care is paid for in this country, cumulatively combine to create a set of conditions and needs that do not exist in other contexts.

As the District Court noted, there are clearly other situations in which spreading the cost of a government program across more citizens would ease the burden on some. In light of the Government's financial support for General Motors ("GM"), taxpayers might benefit if citizens were required to buy GM cars. However, an individual's decision not to buy a GM car does not increase the cost

borne by others. When an individual buys a car, he or she bears the full cost. This hypothetical contrasts sharply with the case of uninsured individuals either receiving uncompensated care or engaging in "market timing" behavior where they only pay for insurance when they plan on using medical care or recognize that their medical costs are escalating, thereby inevitably shifting costs to insured individuals.

Likewise, while there are other necessities of life, such as food and shelter, they too do not have the economic characteristics of health care. Because the need for most items is relatively certain in amount and time, people do not insure against the risk that they will need food or shelter. Rather, they plan for those needs, even when their means are limited. Nor are grocery stores or landlords required to provide food or housing to the needy even if they cannot afford to pay. So too, while many families purchase homes, purchasing a home is discretionary decision as living quarters can be rented. And, banks can adjust for the risks of non-payment, and government intervention is unnecessary to address the concerns raised by the Court.[44]

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[44] *See Florida ex rel. Bondi*, 2011 WL 285683, at *24. The District Court's analogizing medical costs and risks to mortgage financing is a strain, at best. The economics of the housing market are fundamentally different from those involved in health care and the recent crisis in the financial markets was largely attributable to unacceptable risk-taking by mortgagors and others in the financial markets. *See, e.g.*, FINANCIAL CRISIS INQUIRY COMMISSION, THE FINANCIAL CRISIS INQUIRY REPORT: FINAL REPORT OF THE NATIONAL COMMISSION ON THE CAUSES OF THE FINANCIAL AND ECONOMIC CRISIS IN THE UNITED STATES xxvii-xx (2011),

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In contrast, virtually all will require health care at some point, medical providers are obligated to provide care, and the costs of much medical care -- especially the most-costly care -- occur unpredictably. These expenses cannot be deferred nor can care be provided in other ways. Rather, the costs are largely borne by others when incurred by an uninsured party.

The District Court's attempt to equate these other necessities with the health care market ignores the totality of the unique characteristics of the health care market. None of the hypothetical situations discussed in its decision involves unavoidable need, unpredictable need, unpredictable costs, the obligation to provide service, and the cost shifting that characterizes the health care market. Indeed, the costs associated with many of the markets discussed by the Court are not typically financed by insurance where the risks are shared by others. Consequently, the assumption underlying the Court's decision -- that Section 1501 regulates inactivity -- is unsustainable: individuals who forego health insurance are not bystanders, but are participants in and dramatically affect both the health insurance and health care markets.

B. *The Decision to Forego Health Care Is Not A Passive Decision.*

A large number of studies in health economics show that insurance decisions respond to economic factors in a manner strongly predicted by models of forward-

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available at http://www.gpo.gov/fdsys/pkg/GPO-FCIC/pdf/GPO-FCIC.pdf. It was not the result of the inherent economic characteristics of the market.

looking behavior, and thus that many individuals forgo insurance as a result of strategic thinking. One finding supporting this view is that about one-quarter of the uninsured reject the offer of employer-sponsored insurance to remain uninsured, despite the significant subsidies that virtually all employers offer for employer-sponsored insurance.[45] Insurance purchase is not a random event; it responds strongly to price and other factors. Other studies show that individuals are more likely to remain uninsured when there are more sources of "uncompensated care" available, such as public hospitals or hospitals that have high uncompensated care spending; the ability to receive free care plays into the decision to be covered.[46]

Still other studies show that when public insurance is expanded to some family members, such as children, families will often drop insurance for all members of the family to take advantage of the partial coverage for children. This exposes the ineligible family members to being uninsured but leads to overall benefits for the family.[47] Finally, evidence from Massachusetts shows that even under the insurance mandate there, some people signed up for insurance but

[45]Gruber, Jonathan and Ebonya Washington (2005). Subsidies to Employee Health Insurance Premiums and the Health Insurance Market, Journal of Health Economics, 24(2), March 2005, p. 253-276.

[46] Rask, Kevin N. and Kimberly J. Rask (2000). "Public Insurance Substituting for Private Insurance: New Evidence Regarding Public Hospitals, Uncompensated Care Funds, and Medicaid".

[47] David Cutler and Jonathan Gruber (1996). The Effect of Expanding the Medicaid Program on Public Insurance, Private Insurance, and Redistribution, American Economic Review, 86(2), May 1996, p. 368-373.

terminated their coverage within a year; such individuals were much sicker than the typical person in the market.[48] The costs of this "adverse selection" were estimated to increase insurance premiums by 0.5 to 1.5%, and ending this loophole -- which Massachusetts has done with the Affordable Care Act -- would lower costs for everyone in the market by 1.2%. This data demonstrates that foregoing health insurance is frequently not "inactivity," as the District Court believed, but an affirmative, rational economic decision.

C. *The Decision to Forego Health Care Insurance Directly Affects Interstate Commerce.*

Contrary to the Court's apparent assertion,[49] the decision to forego health insurance has a profound impact on interstate commerce. The data in the record here and before Congress clearly establish that the collective effect of individual decisions not to purchase health insurance have a profound effect on the costs of health care insurance premiums, the coverage which insurance companies can provide at reasonable rates, and the extent to which the costs of providing health care to the uninsured are borne by others, including the taxpayer. As the District Court recognized, the total costs of uncompensated care in 2008 alone were $43

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[48] Oliver Wyman (2010). "Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets," *available at* http://www.mass.gov/Eoca/docs/doi/Companies/adverse_selection_report.pdf.

[49] *Florida ex rel. Bondi*, 2011 WL 285683, at *26.

billion.[50] And, as the experience in Massachusetts noted above demonstrates, decisions by individuals to opt out of a health insurance program increases the costs of health insurance to others.

Further, the Court's conclusion that five steps are necessary for the decision to forego purchasing health insurance to affect interstate commerce[51] overlooks the characteristics of the health care market. For example, medical conditions often get worse over time and ignoring them at the early stages increases the ultimate cost of treating the condition. Thus, an individual may forgo preventive care when uninsured and, as a result, his or her medical costs are higher later when the condition is addressed. The decision to forego medical care imposes costs on others, contrary to the District Court's holding. The same is true with some types of curative care. One may forgo such care today if they are sick, but use more of that care in the future, when once they get coverage. Thus, the District Court's reliance on *Lopez*'s[52] prohibition against "piling 'inference upon inference'" is misplaced.[53] The record developed by Congress establishes that the decision not to

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[50] *Id.*

[51] *Id.*

[52] *United States v. Lopez,* 514 U.S. 549, 115 S. Ct. 1624 (1995),

[53] *See Florida ex rel. Bondi*, 2011 WL 285683, at *26 (quoting *Lopez,* 514 U.S. at 567); *but see Thomas More Law Center*, 720 F. Supp. 2d at 894 ("This … cost-shifting is what makes the health care market unique. Far from 'inactivity,' by choosing to forgo insurance plaintiffs are making an economic decision … to pay for health care services later,… rather than now through the purchase of insurance, collectively shifting billions of dollars, $43 billion in 2008, onto other market participants. As this cost-shifting is exactly what the Health Care Reform Act was

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purchase health insurance when writ large against the public as a whole has a direct and immediate impact on interstate commerce.

Several district courts have agreed with these findings and their implications, recognizing that the ACA is designed to address failures in the health care insurance market that make it prohibitively difficult for many individuals to afford or obtain health insurance and produce escalating health care costs for consumers and taxpayers.[54] The decision to require most individuals who can afford it to obtain health insurance is a reasonable approach, as a matter of economics, to satisfying the ACA's overarching goals in reforming health insurance and creating a fairer and more efficient health care system.[55] The economic characteristics and principles that underlie this conclusion are, however, not common to other markets. In short, Section 1501 is a measured response to a unique market imperfection arising from characteristics that do not exist in other markets. Upholding that necessary corrective measure will not open the floodgates of unfettered federal power to require individuals to purchase goods and services or engage in activity that may be good for them.

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enacted to address, there is no need for metaphysical gymnastics of the sort proscribed by *Lopez*.").

[54] *Liberty Univ.*, 2010 WL 4860299, at *14-15; *Thomas More Law Center*, 720 F. Supp. 2d at 894-95.

[55] *See*, J. Gruber, Health Care Reform without the Individual Mandate, Center for American Progress (Feb. 2011), *available at* http://www.americanprogress.org/issues/2011/02/gruber_mandate.html.

CONCLUSION

For the reasons set forth above, *Amici* urge the Court to reverse the decision below and uphold Section 1501. Spreading the costs of medical care across the broad spectrum of the population that will require medical assistance is essential to reforming the health care system in the United States and achieving the legitimate goals of the Act. While the minimum coverage requirement may appear unique, it is, as an economic matter, consistent with the other obligations imposed under the Commerce Clause. As Judge Moon of the Western District of Virginia held, it is a regulation of "economic decisions … [that have] a substantial impact on the national market for health care …."[56] Given the unique economic characteristics of health care, upholding that requirement will not authorize a vast expansion of federal power.

[56] *Liberty Univ.*, 2010 WL 4860299, at *15; *accord Mead v. Holder*, 2011 WL 611139, at *15-16 (D.D.C. Feb. 22, 2011); *Thomas More Law Center*, 720 F. Supp. 2d at 894.

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7), I hereby certify that, excluding the materials authorized to be excluded from the word count by 11th Cir. R. 32-4, this brief contains 6995 words. I have relied on a word-processing system for the word count. I further certify that this brief has been prepared in a proportionally spaced typeface utilizing 14-point Times New Roman font.

This 8th day of April, 2011.

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This is to certify that, pursuant to Fed. R. App. P. 25(a)(2)(B), I caused to be filed the "**BRIEF AMICI CURIAE OF ECONOMIC SCHOLARS IN SUPPORT OF APPELLANTS**" by dispatching the same to a third-party commercial carrier for delivery to the clerk, addressed to:

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