DOCKET NOS. 11-11021 & 11-11067

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.

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

BRIEF FOR AMICI CURIAE ECONOMISTS IN SUPPORT OF APPELLEES/CROSS-APPELLANTS AND AFFIRMANCE

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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 Servs., 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 the below-listed individual Amici Curiae economists are non-corporate individuals. To the best of the undersigned's knowledge, the list of persons, firms, and associations contained in the Certificate of Interested Persons filed by the National Federation of Independent Business, Kaj Ahlburg, and Mary Brown (the "Private Plaintiff-Appellees"), and set forth at pages C-1 through C-9 of Private-Plaintiff Appellees' opening brief, is complete and accurate. That Certificate of Interested Persons is incorporated by reference herein.

In addition, the undersigned lists the following as additional persons that may have an interest in the outcome of this case:

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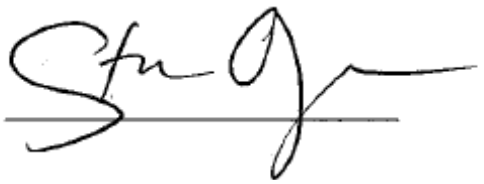

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INTEREST OF AMICI CURIAE[1]

Amici Curiae are 105 economists who have studied, researched, and participated in the national policy discussion relating to the healthcare markets. Amici include Nobel laureates, former senior government officials, and faculty from research universities around the country. *See supra* pp. C-1 through C-10. Amici support the need for reform, but believe that the recent federal legislation will likely exacerbate, rather than constrain, the inflation in healthcare costs that poses a serious long-term challenge to the U.S. economy. Amici submit this brief to provide the Court with a more complete and accurate understanding of the statistics relied upon by the Government and its amici. Those numbers are essential to understanding the individual mandate's true purpose and impact, as well as the shortcomings in the Government's effort to overturn the well-reasoned decision below.

[1] All parties to this appeal have consented to the filing of this brief. Fed. R. App. P. 29(a). No counsel for any party authored this brief in whole or in part, nor did any party, person, or entity other than Amici and their counsel make a monetary contribution to the preparation and submission of this brief.

STATEMENT OF ISSUES

Amici adopt the Restatement of the Case in the brief filed by Private Plaintiffs-Appellees.

SUMMARY OF THE ARGUMENT

In section 1501 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA" or the "Act"), Congress asserted the authority to compel individuals to participate in the market for health insurance. Never before has the Government undertaken such a measure. The question is whether such an unprecedented law is justified as an application of Congress's power to "regulate Commerce . . . among the several States," U.S. Const. art. I, § 8, cl. 3, or a measure "necessary and proper for carrying into Execution" that power, *id.* art. I, § 8, cl. 10.

In trying to make that case, the Government, supported by the amicus brief of the Economic Scholars (the "Economist Amici"), offers a chain of causation that casts individual consumers' decisions to remain outside the health insurance market as an activity that substantially affects interstate commerce by materially increasing the costs of health insurance for all Americans. The Government claims that section 1501, the individual insurance mandate, is a necessary response to address the $43 billion in uncompensated care allegedly caused by the voluntary

decisions of these individuals—who are, by definition, healthy and not poor—not to purchase health insurance. U.S. Br. at 2, 27-28.

The Government and the Economist Amici also repeatedly describe the healthcare industry as "unique," because of its high rates of participation, high costs, federal mandates, and the purported uncertainty surrounding the need for care. U.S. Br. at 9-10; Econ. Br. at 8-14. This emphasis on the "uniqueness" of the market is plainly designed (1) to compensate for the absence of any true limiting principles in their legal argument and (2) to convince the Court that upholding the federal authority to compel market participation here would not do away with the traditional limits on the sweep of Congress's powers in other areas.

The Government's justifications for the individual mandate do not withstand scrutiny, however, because the economic premises on which they rely are demonstrably untrue. The individual mandate has almost nothing to do with cost-shifting in healthcare markets because the targeted population of the mandate plays a minimal role in the $43 billion of uncompensated costs identified by the Government. The mandate was expressly created not to stop cost-shifting, but to compel millions of Americans to pay more for health insurance than they receive in benefits to subsidize both the voluntarily insured and the insurers, and thereby ameliorate the steep rise in premiums that would otherwise be caused by the ACA.

Likewise, the healthcare market is "unique" only in the sense that each snowflake is unique. The economic features relied upon by the Government are not distinct to health care, but are characteristic of many markets. Indeed, frequently, these externalities are not even intrinsic to healthcare markets themselves, but rather reflect distortions caused by federal law. Accordingly, these features can serve as neither a justification for expanded federal regulation nor a genuine limiting principle for the assertion of federal authority reflected in the individual mandate.

1. The Government's claim that the voluntarily uninsured, by staying out of the market, impose $43 billion in uncompensated costs has no basis in fact. While the Government repeatedly invokes this figure, it nowhere identifies the specific costs actually imposed by the individuals compelled by the mandate to purchase health insurance. Yet the Government actually collects such information through the authoritative Medical Expenditure Panel Survey ("MEPS"). Those data show that this class's healthcare costs are well below average, and the total amount of uncompensated costs attributable to it are no more than $8 billion annually, or ***one-third of one percent*** of the Nation's $2.4 trillion in annual healthcare costs. In other words, the individual mandate cannot reasonably be justified on the ground that it remedies the costs imposed on the system by the voluntarily uninsured.

The Government further fails to show that "average" Americans cannot afford their own healthcare costs and thus, the uninsured must *ipso facto* contribute to the cost-shifting problem. Although the Economist Amici emphasize the approximately $6,000 spent by ***the average*** American per year on health care, they provide no analysis of the costs paid by those subject to the mandate. In fact, the undisputed data show that the targets of the mandate on average consume less than one-seventh of that figure.

That the individual mandate has little, if anything, to do with uncompensated care only underscores that the real purpose of the mandate is what the Government here labels its "second" function—namely, maintaining "the viability of the Act's provisions that bar insurers from denying coverage or setting premiums based on medical condition or history." U.S. Br. at 16.

The ACA prevents health insurers from making the basic actuarial decisions that they make in every other insurance market. Insurers may neither withhold health insurance from those with preexisting conditions nor price insurance premiums to match applicants' known actuarial risks. By requiring health insurers to cover the sick and to set premiums based on average costs, these federal requirements would dramatically increase healthcare premiums for all insured Americans, unless Congress at the same time forces the young and healthy with

relatively little need for comprehensive health insurance to enter the market on disadvantageous terms.

Whether or not these requirements are good policy, what is clear as a constitutional matter is that Congress is exercising federal power not to regulate "the consumption of healthcare without insurance," U.S. Br. at 2, but to compel the voluntarily uninsured to purchase insurance at disadvantageous prices, as a quid pro quo for relieving the deleterious effect of related federal requirements. As the District Court recognized, if Congress may regulate noncommercial activity just to fix the distortions caused by federal regulations—present or future—there is no practical limit to its authority. *See Florida ex rel. Bondi v. U.S. Dep't of Health and Human Servs.*, --- F.Supp.2d ---, 2011 WL 285683, at *25-27 (N.D. Fla. Jan. 31, 2011); *cf. United States v. Lopez*, 514 U.S. 549, 563-64, 567-68 (1995).

2. Recognizing the unprecedented exertion of federal authority, and the absence of any true limiting principle, the Government and its amici argue that the healthcare industry is "unique" and thus this Court need not be concerned that upholding the individual mandate will remove any practical limit to Congress's commerce power. The Government's argument dramatically overstates the distinctive characteristics of the healthcare industry, most of which are routinely found in varying degrees in many other markets.

While the presence of market externalities in the healthcare industry cannot expand the constitutional scope of federal power, the Government's inability to impose the insurance mandate need not doom effective healthcare reform, either at the national or the state level. Health care is typically consumed locally, and health insurance markets themselves primarily operate within the States. The Government's attempt to fashion a singular, universal solution is not necessary to address the local externalities arising in these markets and provides no justification for casting aside the traditional constitutional limitations on federal power.

ARGUMENT

I. THE GOVERNMENT'S RELIANCE ON COST SHIFTING IS UNFOUNDED BECAUSE THE INDIVIDUAL MANDATE HAS LITTLE IMPACT ON UNCOMPENSATED HEALTHCARE COSTS.

The Government contends that section 1501's mandate is necessary because people who do not purchase health insurance substantially "affect" markets for medical services by failing to pay for their own care and thus increase the cost of health care for everyone else. U.S. Br. at 10-12. Most strikingly, the Government contends that the individual mandate is necessary to address more than $43 billion in annualized healthcare costs that the voluntarily uninsured allegedly do not pay. *Id.* at 11, 16. According to the Government, these individuals should be regarded as free-riders who take advantage of health care paid for by others and so may sensibly be compelled to bear the costs that they otherwise would shift onto others.

As the Economist Amici further explain:

> [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 billion***.

Econ. Br. at 24-25. The problem with this story is that it is untrue. As a matter of basic economics, the individual mandate has virtually nothing to do with the alleged $43 billion of uncompensated costs cited by the Government. Instead, the mandate is designed to subsidize the dramatic increase in costs that the requirements of the Act itself will impose on health insurers.

A. There Is No Evidence That Individuals Who Choose To Forgo Insurance Are a Financial Burden on the Healthcare System.

The Government's argument that the voluntarily uninsured impose $43 billion on the rest of the economy lacks any support. The Government provides none and in fact, the Congressional Budget Office ("CBO") has recognized that the ACA will "have minimal effects on . . . cost shifting."[2]

The individual mandate, by definition, targets people who ***choose*** not to purchase health insurance and are not otherwise covered by Medicaid or Medicare.

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[2] CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, 6 (Nov. 30, 2009) ("Premiums"), *available at* http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

These people tend to be younger, healthier, and less in need of medical care.[3] These citizens make the rational economic decision to pay for their relatively modest healthcare expenditures out of pocket, rather than purchasing health insurance. Indeed, if they needed health insurance at all, they would require only the relatively inexpensive insurance limited to covering catastrophic care, a market now foreclosed by the ACA.

There is no good economic evidence that when such people do require medical care, the cost of that care is passed on to others in a manner that increases the costs of health insurance. In fact, those who willfully choose to forgo insurance tend to ***overcompensate*** the market for their own care relative to other consumers of healthcare services because they generally pay their medical bills and are not able to obtain care at prices negotiated by insurance providers.[4]

1. The Individual Mandate Will Contribute Little Toward Recovering the $43 Billion in Uncompensated Healthcare Costs Invoked by the Government.

The individual mandate plainly cannot be justified as a solution to the alleged cost-shifting problem. The Government's $43 billion figure comes from analyses of healthcare costs contained in the MEPS dataset, which comprises data

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[3] Kaiser Commission, *Covering the Uninsured in 2008*, 60 (Aug. 2008), *available at* http://kff.org/uninsured/upload/7809.pdf.

[4] Jonathan Gruber & David Rodriquez, "How Much Uncompensated Care Do Doctors Provide?," 26 *J. Health Econ.* 1151, 1159-61 (Dec. 2007).

from large-scale surveys of families and individuals, their medical providers, and employers and is the most complete source of data on health care expenditures in the United States. MEPS is collected and maintained under the auspices of the U.S. Department of Health and Human Services.[5]

As a threshold matter, the Government's reliance on the alleged $43 billion in uncompensated care makes a serious impression only until one realizes that the total value of the healthcare market in 2008 was roughly ***$2.4 trillion***. As the CBO has stated, "the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance."[6] Thus, even if accurate, the $43 billion in uncompensated care, while not insignificant, still represents less than 1.8 percent of the overall market.[7]

Even that 1.8 percent, however, is quite misleading because it represents ***the totality*** of uncompensated care in the healthcare system, not the costs associated with the voluntarily uninsured. Indeed, the MEPS data reveals that the actual portion of uncompensated care ***attributable to those subject to the individual mandate*** is vastly smaller, and in fact constitutes less than one-third of one percent of the overall market for health care.

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[5] *See* http://www.meps.ahrq.gov/mepsweb.

[6] CBO, Premiums, 12-13; *see also id.* at 16.

[7] Centers for Medicare & Medicaid Services ("CMS"), National Health Expenditure 2009 Highlights, at Table 1 (2011).

Perhaps the easiest way to see this reality is to start from the $43 billion figure and to subtract from it the uncompensated costs that will not be affected by the individual mandate:

- *Preexisting conditions*. $8.7 billion of the $43 billion reflects care rendered to individuals who would purchase health insurance, but whose preexisting conditions prevented them from doing so; under the Act, they would be guaranteed coverage and so would no longer be uninsured;[8]
- *Medicaid Recipients*. Of the remaining $34.3 billion, roughly $15 billion must be deducted for cost-shifters who are now newly eligible for Medicaid based on the Act's expansion of insurance to all individuals and households whose income is at or below 133 percent of the poverty line;[9]
- *Illegal Immigrants and Other Nonresidents.* Of the remaining $19.3 billion, roughly $8.1 billion is attributable to uncompensated care provided to illegal aliens or other nonresidents of the United States, who will not be subject to the mandate at all;[10] and
- *Payments Owed by the Insured*. Of the remaining $10.6 billion, another $3.3 billion is attributable to care rendered to insured individuals who nonetheless did not pay their out-of-pocket share, such as co-payments or the like.[11] The ACA would have no effect on these cost-shifters.

Thus, the ***maximum*** share of uncompensated care attributable to the mandate's target class is less than $8 billion, or less than ***one-third of one percent***

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[8] 42 U.S.C. § 300gg-3.

[9] *Id.* § 1396a(a)(10)(A)(i)(VIII).

[10] 26 U.S.C. § 5000A(d)(3).

[11] Exhibit A explains the methodology by which these numbers were obtained. These figures reflect weighted estimates based on provider recovery rates (*i.e.*, the amount that providers typically recover after treatment). Appendix A also includes the unweighted numbers, which in fact result in an even smaller amount (reflecting the greater recovery rate from those affected by the mandate).

of the healthcare market.[12] The actual figure is almost certainly smaller. Accordingly, the voluntarily uninsured, who choose to pay their own relatively modest healthcare costs out of pocket, thus plainly cannot be described as villains who impose significant uncompensated costs on others. The Government cannot rationally justify the individual mandate as a response to the miniscule amount of uncompensated care posed by the class subject to the mandate.

2. The Government and Its Amici Overstate the Economic Burden that Health Care Imposes on the Voluntarily Uninsured.

Apart from invoking the $43 billion figure, the Government and its amici contend that the voluntarily uninsured must receive uncompensated care because participation in the market is "essentially universal" and frequently expensive. U.S. Br. at 7. The Economist Amici offer some specifics. They claim that the "average person" in 2007 used $6,186 in "personal healthcare services," which is "over 10 percent of the median family's income." Econ. Br. at 11. Because health care is universal and expensive, the Economist Amici reason, everyone who does not obtain insurance must be in the business of cost-shifting. *Id.* The Government too

[12] This analysis is consistent with a recent study of California's healthcare system, which concluded that "[c]ost shifting from the [voluntarily] uninsured is minimal." Daniel P. Kessler, "Cost Shifting in California Hospitals: What Is the Effect on Private Payers?," California Foundation for Commerce and Education (2007), *available at* http://www.cornerstone.com/files/CaseStudy/9bc04cf2-dd57-4f1d-ab3c-e5e0d5e7c96e/Presentation/CaseStudyFile/4796ca54-3a8a-4676-a61c-4c4b9f5a5272/Kessler_CFCE_Cost_Shift_Study%206-6-07.pdf.

emphasizes how this costliness renders the payment of medical bills without insurance so difficult that only the mandate can forestall the inevitable cost-shifting. *See* U.S. Br. at 10-12.

But statistics designed to show that the "average" person consumes a substantial amount of health care tell the Court nothing about the healthcare costs of those targeted by the mandate. As Mark Twain knew, statistics can be grossly misleading unless apples are compared with apples, and oranges with oranges.[13] Thus, the Government and its amici conflate a singular category of healthcare consumers—the young, healthy, and voluntarily uninsured—with the aggregate market, from which the narrower category differs in marked respects.

The mandate is not targeted against the "average" American in the healthcare market. It is meant to address adverse selection, and it is directed at younger, healthy individuals who, in the absence of such a mandate, would make an economically rational choice to forgo health insurance. *See* 42 U.S.C. § 18091(a)(2)(I); Econ. Br. at 17-18. As might be expected, this class consumes only a fraction of the national average in healthcare services per year. In fact, in 2010, the voluntarily uninsured consumed, on average, only $854 in healthcare services, approximately 14 percent of the claimed "average" healthcare

[13] Mark Twain, "Chapters from My Autobiography," *North American Review*, *available at* http://www.gutenberg.org/files/19987/19987-h/19987-h.htm (observing that "[t]here are three kinds of lies: lies, damned lies, and statistics").

expenditure. That figure, moreover, constitutes less than 1.1 percent of an average family's yearly income based on the most recent available data, a far cry from the 10 percent costs of the "average" American.[14] *Cf.* Econ. Br. at 11. Thus, with regard to the specific class of persons targeted by the mandate, the Government's argument that their health care is too expensive to afford is simply not borne out by the data.

The Economist Amici employ similarly flawed logic in arguing that because federal law requires emergency stabilization care, the voluntarily uninsured are an inherent cause of uncompensated care. *See* Econ. Br. at 13. Once again, the data show that the targets of the mandate consume ***only $56*** per year on average in ***total*** emergency-room care, which includes both the mandated emergency stabilization care (which may still be billed to patients) and the more routine care administered there. *See* Appendix A. The data thus provides no evidence that the voluntarily uninsured are, as a class, receiving significant amounts of uncompensated care such that one could rationally justify the individual mandate as a solution to this purported cost-shifting problem.

[14] *See* 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, A5 (Feb. 2009). In 2007, the average household earned roughly $84,000.

B. The Individual Mandate Was Never About Addressing the Costs of Uncompensated Care.

The conclusion that the individual mandate will have little impact on reducing the costs of uncompensated care should not be particularly surprising to anyone, economist or otherwise, who has studied the healthcare markets, because Congress did not enact the individual mandate to target uncompensated care or even to address any market failures caused by the private market for health insurance. *See* 42 U.S.C. §§ 18091(a)(2)(C), 18091(a)(2)(I) (explaining that the mandate forces "healthy individuals" into the market as "new consumers" to reduce insurers' costs). The Government itself acknowledges that the individual mandate "is key to the viability of the Act's provisions that bar insurers from denying coverage or setting premiums based on medical condition or history." U.S. Br. at 16.[15]

In purpose and effect, the individual mandate is designed to compensate health insurers for the fundamental distortions caused by the heavy hand of federal regulations under the ACA. In the name of expanding coverage, Congress prohibited insurers from making the basic pricing decisions that they otherwise

[15] That the ACA was never grounded in an attempt to curb cost-shifting is likewise strikingly clear in Congress's half-hearted commitment to compel compliance. The penalties set by the mandate are modest enough that many "free riders" would rationally choose to pay them rather than purchase insurance, *see* 26 U.S.C. § 5000A, and the Act liberally excuses individuals from the mandate for purposes of "hardship," *see id.*

would make as rational economic actors. The ACA requires insurers to provide health coverage to those with preexisting conditions, *see* 42 U.S.C. §§ 300gg-1(a), 300gg-3(a). More significantly, insurers may not price healthcare coverage based on the actuarial risks posed by a class of applicants, but must employ "community-rated" premiums—*i.e.*, premiums based on the average costs of the insurance pool, *see id.* § 300gg.

The ACA's prohibition on traditional means of pricing the insurance pool disrupts the market function of rating insurance premiums based on the probabilities of unexpected medical conditions. The Act makes health insurance an entitlement, which insurers must provide irrespective of individual characteristics. By forcing health insurers to cover those with expensive medical conditions and to set premiums based on average costs, the ACA would cause healthcare premiums for everyone to rise dramatically. The CBO has estimated that the ACA will cause costs for health insurance in the individual market to rise 27 to 30 percent over current levels in 2016.[16]

Congress thus imposed the individual mandate to subsidize health insurers and lower the premiums for voluntary consumers by compelling individuals, no matter how young and healthy, to pay for health insurance they do not want, at premiums that ensure they will pay more than they will receive in benefits. By

[16] CBO, Premiums, 6.

forcing consumers to engage in economically disadvantageous transactions, Congress sought to mitigate the regulatory costs imposed on insurers and the sharp rise in healthcare premiums caused by the ACA.

The CBO estimates that the individual mandate will have the effect of reducing premiums for those currently uninsured by choice between $28 and $39 billion in 2016 alone.[17] In other words, the roughly 8 million Americans the CBO estimates will be subject to the mandate will be forced to purchase health insurance at elevated premiums for the sole purpose of subsidizing the premiums of those who voluntarily enter the private health insurance market. Such a subsidy obviously has no correlation to the alleged cost-shifting practices of the voluntarily insured and everything to do with making more palatable the rise in healthcare premiums that the ACA itself will inevitably impose.

Thus, those subject to the mandate have not contributed materially to the cost-shifting problem identified by the Government. Instead, using the individual mandate as a subsidy, Congress was compensating for the market effects of its own actions. Whatever one might say about such a course as a policy matter, the constitutional implications of permitting such bootstrapping as a valid regulation of interstate commerce are sweeping and unprecedented.

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[17] *Id.*

II. THE GOVERNMENT CANNOT RELY ON THE "UNIQUE" FEATURES OF THE HEALTHCARE MARKET AS A LIMIT ON THE EXERCISE OF FEDERAL POWER HERE.

The Government and the Economist Amici argue that the economics of the healthcare industry are "unique" and therefore warrant an unprecedented expansion of Congress's Commerce Clause authority. *See* U.S. Br. at 7-10; Econ. Br. at 5, 8-19. While the healthcare industry, like all markets, may suffer from externalities and inefficiencies, market failures alone do not free the federal Government from the traditional limitation that it regulate only "***activities*** that arise out of or are connected with a commercial transaction." *Lopez*, 514 U.S. at 561 (emphasis added). Yet the Economist Amici suggest that because the healthcare market differs so greatly from other markets, this Court need not worry that upholding section 1501 would permit widespread federal regulation of inactivity in other contexts. *See* Econ. Br. at 2, 20-26. Aside from implicitly acknowledging the extraordinary nature of the Government's argument, these claims of "uniqueness" fail on their own terms because they suffer from logical leaps and imprecise economics.

A. The Need for "Health Care" Is Not Uniquely "Unavoidable."

The Government and its amici assert that participation in the healthcare market is "essentially universal," U.S. Br. at 7, and "unavoidable," Econ. Br. 20-22. Such statements are gross oversimplifications. Health care does not refer to a

single physical good—like an apple or a book—but to a complex array of goods and services, the need for and cost of which have changed with medical advances, cultural shifts, and technological developments. A person does not "need" health care in the same way a person "needs" to eat. Indeed, individuals' use of health care can vary dramatically due to their religious beliefs, health profiles, income, geography, and many other factors.

It is generally true that most people receive medical care at some point. At this level of abstraction, however, there are numerous economic markets in which participation may be deemed to be universal. Virtually all Americans will participate in the "transportation" market in one way or another, whether they drive a car, ride a bus, or take a train. Likewise, all Americans will participate in the "food" market insofar as the consumption of food—in contrast to health care—actually does constitute a necessary human activity.

In other words, for the Government to claim that the market for health care is "unavoidable," or even that it is important, is not to say that it is materially distinct from many other markets that are valued and common in modern American life. The healthcare market, like these other markets, remains subject to the basic laws of supply and demand and consumer choice, and it is these laws that will determine the kinds and amounts of goods and services purchased by consumers. Health care involves a wide range of available treatments and costs,

and there is hardly an "unavoidable" need for many of the expensive procedures and treatments that some individuals may choose, or that some forms of insurance may cover. Likewise, Congress's labeling of a given procedure or service as "essential" does not necessarily make it so as an economic matter.[18] Thus, at bottom, the assertion that health care is "unavoidable" only raises the question what services "health care" should encompass and what portion of that care, if any, is truly unavoidable.

B. The Need for Health Care Is Not Uniquely Unpredictable.

The Government and its amici also assert that health care is unique in that its costs can be unpredictable. *See* U.S. Br. at 7; Econ. Br. at 5, 10. But virtually every insurance product is designed to cover the costs of some occurrence that is unpredictable and that may involve risks that are unknown or unexpected. No doubt, medical emergencies or other health crises can unexpectedly result in higher costs. That is why many people would choose to purchase health insurance, even without the federal subsidization of the healthcare insurance market.

In fact, however, the routine costs of care for most people are fairly predictable. The average expenditures per year per person are calculated and

[18] The ACA actually purports to define "essential" health benefits in a way that includes a host of routine and predictable medical services, including "preventive and wellness services," "prescription drugs," and "pediatric services, including oral and vision care." 42 U.S.C. § 18022.

published with regularity.[19] Moreover, most people can assess their own medical expenses and, taking into account past doctor's visits and medication needs, reasonably estimate costs for the coming year. Millions of people do this every year when they elect to use flexible spending accounts as part of a pre-tax benefit. Such accounts are generally "use it or lose it" and thus require participants to commit to the amount for which they plan to seek reimbursement for medical expenses in the coming year. Thus, when the Government and its amici assert that the need for healthcare services is unpredictable, all they can really plausibly mean is that the need for ***catastrophic*** care is unpredictable.

Catastrophic loss, however, is hardly unique to the healthcare industry. A family could be more financially devastated by a fire or flood that destroys their home, or by an accident that totals the family car, than by unexpected medical expenses. What is different about the healthcare industry, perhaps, is that the ACA actually disfavors insurance for catastrophic care and instead mandates coverage for "essential" healthcare features that include, in substantial part, routine and predictable healthcare costs. *See* 42 U.S.C. § 18022. Thus, the individual mandate can hardly be justified by the proposition that health insurance is needed to handle catastrophic care, and the claim that the Government should have greater authority

[19] *See, e.g.*, CMS, National Health Expenditure 2009 Highlights (2011).

to regulate the healthcare market because the risk of catastrophic loss is unpredictable suffers from the absence of any limiting principle.

The Government's argument that the healthcare market is unique because it is "unpredictable" carries no water: Routine care is, in fact, quite predictable, and the desire for insurance to address catastrophic occurrences is endemic to every market for insurance.

C. The High Cost of Care Does Not Differentiate the Healthcare Industry from Other Markets.

Relatedly, the high cost of modern health care provides no basis for treating the healthcare industry differently from other markets. The Economist Amici contend that health care is unique because "medical care is so expensive [that] essentially everyone must have some access to funds beyond their own resources in order to afford it." Econ. Br. at 11. Once again, this argument lacks any limiting principle. The basis for a constitutional rule cannot turn on a price index or the amount of consumption funded by insurance versus personal funds.

Moreover, as discussed above, this argument depends on misleading statistics that conflate the healthcare costs spent by the insured, including Medicare recipients, with the much lower costs of the voluntarily uninsured. Indeed, millions of Americans have demonstrated this fallacy by voting with their wallets and electing to pay for their health care out of pocket for some period of time. Indeed, this group is the very one the individual mandate seeks to regulate.

D. The Healthcare Market Is Not "Unique" Merely Because the Government Has Legislated Inefficiencies into the Market.

In contending that the healthcare market is unique, the Government identifies one feature of the market that is a direct result of federal regulation—consumers receive emergency services irrespective of their ability to pay because providers are required to provide certain types of care. *See* 42 U.S.C. § 1395dd.

The federal requirement to provide care applies only to emergency-stabilization care. Emergency care as a whole (of which federally mandated stabilization care is a subset) comprises less than 3 percent of the total healthcare market, and only about half of that care goes uncompensated.[20] Thus, the Government's argument rests on a relatively small piece of the healthcare industry.

Even so, this feature of health care is not innate to the market, but is the byproduct of the federal regulatory regime. It is thus circular for the Government to claim authority to regulate a unique type of market externality that it has itself created. As the Brief for the Private Plaintiffs-Appellees explains, the Government cannot justify the expansion of federal power under the Necessary and Proper Clause as necessary to cure the adverse impact of federal regulations. *See* Private Pltfs.' Br. at 34-37.

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[20] *See* American College of Emergency Physicians, "Costs of Emergency Care," *available at* http://www.acep.org/content.aspx?id=25902; CMS, National Health Expenditure 2009 Highlights, Table 1 (2011).

To take another analogy, it is well established that a law enforcement officer may not create an exigency and then use it as an excuse for failure to obtain a warrant. *See, e.g.*, *Johnson v. United States*, 333 U.S. 10 (1948); *United States v. Tobin*, 923 F.2d 1506, 1511 (11th Cir. 1991) ("a warrantless search is illegal when police . . . create exigent circumstances"). Likewise, a prosecutor may not delay a prosecution and then seek relief from the Speedy Trial Clause of the Sixth Amendment. *See, e.g.*, *United States v. Marion*, 404 U.S. 307, 325 (1971); *United States v. Ingram*, 446 F.3d 1332 (11th Cir. 2006). Nor may the federal Government spend years neglecting the disposal of hazardous nuclear waste and then coerce the States to take title to the waste. *See New York v. United States*, 505 U.S. 144, 188 (1992). These cases recognize the commonsense proposition that the Government may not ***enlarge*** its powers in order to fix a mess of its own making.

While there may be good reasons underlying many federal regulations in the healthcare industry, the Government may not point to externalities created by those regulations as supplying the justification for regulations outside its traditional enumerated powers. The impact of federally required emergency stabilization care thus cannot form the basis for expanding the federal power to regulate activity beyond Congress's enumerated powers.

E. The True Externalities in the Healthcare Market Ultimately Are Local and Fully Subject to the Police Powers of the States.

The mere fact that the healthcare market suffers from certain externalities cannot alone justify the expansion of federal power to regulate a decision not to participate in the healthcare market. *See Printz v. United States*, 521 U.S. 898, 933 (1997) ("the Constitution … divides power among sovereigns … precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day"). Even so, the District Court's conclusion that Congress may not compel market participation under the Commerce Clause will not leave the States without their traditional powers to regulate healthcare services.

Indeed, the States have the full power to address such externalities because the markets at issue are fundamentally local in nature. The "national healthcare market" that the Government describes is nothing more than an aggregation of disparate ***local*** healthcare markets. The majority of healthcare providers service consumers of care within a specific geographical area. Health insurers are subject to stringent state regulation limiting, among other things, insurers' ability to sell health insurance across state boundaries. The business of insurance, of course, has traditionally been regulated by the States, *see, e.g.*, 15 U.S.C. § 1012, and it will continue to be so, even under the ACA.

As the Economist Amici emphasize, the individual mandate is a policy that was first adopted in certain States, such as Massachusetts. Those States have

employed a myriad of approaches to solving challenges arising from the healthcare market, including by expanding existing public programs, providing incentives for small businesses to offer private insurance, subsidizing premiums, requiring employers to offer insurance, and mandating individual insurance, to name a few. In these and other policies, the States have formulated various solutions to address the general problems associated with rising healthcare costs and the specific externalities and distortions affecting local markets.[21]

Although many States have made this case in challenging the individual mandate, several have filed amicus briefs supporting the Government. Those State Amici support the Government's position because the ACA's federal subsidies, including the individual mandate, may reduce the States' own healthcare costs. *See, e.g.*, State Amici Br. at 2. That certain States have a fiscal motivation to support the Act is understandable, but the fact remains that the States within our constitutional system have both the traditional power and the practical ability to enact meaningful healthcare reform. Accordingly, a decision by this Court to

[21] For a comprehensive survey of state healthcare reform legislation, *see, e.g.*, John E. McDonough, et al., "A Progress Report On State Health Access Reform," Health Affairs, 27, no.2 (2008), *available at* http://content.healthaffairs.org/content/27/2/w105.full.html; *see also* Amy M. Lischko and Kristin Manzolillo, "An Interim Report Card on Massachusetts Heath Care Reform, Part 1: Increasing Access," Pioneer Institute, 12 (2010) (concluding "the reform has been successful at insuring more Massachusetts residents"); Healthcare for All Kids, *available at* http://www.allkidscovered.com (guaranteeing health insurance to all children in the Illinois).

reaffirm the traditional constitutional boundaries on Congress's power to regulate commerce will encourage and promote State-sponsored and administrated solutions that reflect the appropriate workings among the laboratories of democracy in our federal system.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment below.

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APPENDIX A

METHODOLOGY OF STATISTICAL ANALYSIS

The statistics cited by Amici were calculated using the Medical Expenditure Panel Survey (MEPS) dataset according to the following methodology:

- **<u>Spending by the Young, Healthy, and Uninsured</u>:** The "young, healthy and uninsured" population was derived from the following MEPS dataset variables for the 2008 Household panel survey using SAS software:

  NOT

  - ASTHDXY2=1 OR (has asthma)
  - ARTHDXY2=1 OR (has arthritis)
  - DIABDXY2=1 OR (has diabetes)
  - CHBRON5 =1 OR (has bronchitis)
  - EMPHDXY2=1 OR (has emphysema)
  - CHDDXY2 =1 OR (has coronary heart disease)
  - BPMLDXY2=1 OR (has high blood press)
  - CANCERY2 NE (has history of any cancer)

  AND

  - Age between 21 and 35

  AND

  - PRVEVY2 ne 1 (no private health insurance in 2008)

- PUBAPY2X ne 1 (no public health insurance in 2008)

These variables yield a total population of approximately 11,970,000 with aggregate health spending of about $10,226,000,000. The average health care costs by this class may be expressed as:

($10,226,000,000) / (11,970,000) = $854

The aggregate emergency room spending for this population was $676,000,000. Thus, the average costs of emergency care are:

($676,000,000) / (11,970,000) = $56

- **Uncompensated Care**: Based on $43 billion per year in total uncompensated costs, that sum was apportioned among the various populations contributing to uncompensated care.

  First, the following groups receiving uncompensated care were identified from the MEPS dataset:

  - Uninsured individuals with previously existing conditions;
  - Individuals or households earning less than 133% of the federal poverty line;
  - Illegal aliens or nonresidents of the United States;
  - Insured individuals who did not pay their out of pocket share;
  - The young, healthy, and uninsured.

To determine uncompensated care, the MEPS data were employed to identify individuals who, at the time of billing by their healthcare provider, did not have insurance:

Population	Uncompensated Care $ (in millions)	Percentage of $43 billion
Previously existing condition:	$15,271	35.5%
133% of the poverty line:	$6,600	15.3%
Undocumented or non-residents:	$7,182	16.7%
Insured but unpaid:	$8,685	20.2%
Young, healthy, uninsured:	$5,263	12.2%
TOTAL	~$43,000	100%

The raw data establish about $5.3 billion in uncompensated costs for the target category. Population-specific recovery rates then were calculated for each sub-population based on market data in Steven Parente, "Health Information Technology and Financing's Next Frontier: The Potential of Medical Banking," *Business Economics* (Jan. 2009). The weighted recovery

rates are as follows, along with the adjusted yield by population:

Population	Adjusted Recovery Rate	Adjusted Uncompensated Care $ (in millions)	Percentage of $43 billion
Previously existing condition:	0.4	$8,656	20.1%
133% of the poverty line:	0.1	$14,965	34.8%
Undocumented or non-residents:	0.2	$8,142	18.9%
Insured but unpaid:	0.6	$3,282	7.6%
Young, healthy, uninsured:	0.15	$7,956	18.5%
TOTAL		~$43,000	100%

The approximately $8 billion in adjusted uncompensated costs from the young, healthy, and uninsured can be expressed as a percentage of the overall healthcare market of $2.4 trillion as:

($8,000,000,000) (100) / ($2,400,000,000,000) = 0.33%

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation provided in Rule 32(a)(7) of the Federal Rules of Appellate Procedure. The foregoing brief contains 6,594 words of Times New Roman (14 pt) proportional type. Microsoft Word was used to prepare the brief and calculate the number of words.

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