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Virginia v. Sebelius - Economics Professors Amicus Brief

Kenneth Arrow

George Akerlof

Eric Maskin

Nos. 11-1057 & 11-1058

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

COMMONWEALTH OF VIRGINIA, EX REL. KENNETH T. CUCCINELLI, II, in his official capacity as Attorney General of Virginia,
Plaintiff-Appellee/Cross-Appellant,

v.

KATHLEEN SEBELIUS, Secretary of the Department of Health and Human Services, in her official capacity,
Defendant-Appellant/Cross-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

BRIEF AMICI CURIAE OF ECONOMIC SCHOLARS
IN SUPPORT OF APPELLANT

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BRIEF AMICI CURIAE OF ECONOMIC SCHOLARS IN SUPPORT OF DEFENDANT-APPELLANT[2]

Amici Curiae hereby submit this brief[3] urging reversal of the decision of the United States District Court for the Eastern District of Virginia[4] striking down Section 1501 of the Patient Protection and Affordable Care Act ("ACA" or "Act").[5] That Section requires, with certain exceptions, all Americans who can afford a minimum level of health insurance to 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 recognized scholars in economics, including three Nobel laureates,[6] two recipients of the John Bates Clark Medal for the outstanding American economist aged 40

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[2] The list of Amici Curiae is attached as an Appendix to this Brief.

[3] Counsel for Appellants and for 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] *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).

[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).

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

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, which *Amici* have filed versions of in several of the other cases challenging the constitutionality of Section 1501, including *Liberty University v. Geithner*,[8] 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. 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 their health care, and the requirements of Section 1501 of the Act assure that all Americans, to the extent that they can afford it, contribute to the costs of their own health care by maintaining reasonable insurance coverage. Without it, those costs will be borne

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

[8] --- F. Supp. 2d ---, 2010 WL 4860299 (W.D. Va. 2010), *appeal docketed*, No. 10-2347 (4th Cir. Dec. 3, 2010).

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 impose this obligation will not result in the vast expansion of federal power portrayed by the Appellee and of concern to the court below.[10] As explained 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 them, the need for the kind of requirements adopted in Section 1501 does not exist and the predicate for similar legislative mandates is absent. Hence, contrary to Appellee's claims, affirming Congress'

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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.

[10] *Virginia ex rel. Cuccinelli*, 728 F. Supp. 2d 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."); *see also Florida ex rel. McCollum v. U.S. Dep't of Health and Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010).

power to adopt Section 1501 will not open the door to unfettered encroachment of federal power upon individual liberty.

ARGUMENT

The Appellee contends that the individual mandate to acquire health insurance under Section 1501 embodies an unprecedented effort to expand the scope of federal power by requiring that individuals engage in a prescribed form of economic activity. Notably, the Appellee argues that Section 1501 exceeds the boundaries of Congressional authority under the Commerce Clause by extending federal regulation beyond the economic activity of voluntary health insurance consumers to the so-called inactive nature of individuals who allegedly choose to not participate in commerce when they eschew insurance protection. Rooted in the purported distinction between activity and inactivity, the Appellee asserts that upholding the constitutionality of the ACA under the Commerce Clause will create what would essentially be an expansive "national police power."[11] Notwithstanding solid Supreme Court authority confirming the breadth of Congressional power to regulate when necessary and appropriate to achieve an objective within its powers under the Commerce Clause, the Appellee asserts that Congress lacks the power to require individuals to purchase health insurance.

[11] *See* Pl.'s Mem. in Opp'n to the Secretary's Mot. for Summ. J. at 21, *Commonwealth ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010) (No. 3:10CV188-HEH).

The fundamental flaw with the Appellee's constitutional challenge to Section 1501 is that it relies on a false distinction, lacking any constitutional significance, between economic activity and inactivity. In the context of health care, although the decision to not purchase 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 impacts the cost of health care for other individuals and the overall operation of the interstate health care and health insurance markets. Section 1501 is a tailored response to these circumstances, assuring that all bear a share of the medical expenses they will inevitably demand, rather than merely imposing the costs largely or entirely on others. Consequently, the underlying economics of the health care market clearly justify Congress' adoption of Section 1501.[12] Moreover, contrary to the Appellee's fears, upholding Congress' power to enact the individual mandate will not produce a vast expansion of federal power over personal decisions.

[12] *See Liberty Univ. v. Geithner*, --- F. Supp. 2d ---, 2010 WL 4860299, No. 6:10-cv-00015-nkm, at *15 (W.D. Va. Nov. 30, 2010) ("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 v. Obama*, 720 F. Supp. 2d 882, 894 (E.D. Mich. 2010).

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").[13] One requirement for market optimality is that people know what they need, and 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 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).

Finally, it must be that there is 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,

[13] 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.

economists do not approach the health care industry with anywhere near the deference to individual choice or the expectations of optimality that they do 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."[14] That remains true today.

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

[14] Arrow, *supra* note 13, at 967.

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.[15] By another metric, even the best risk adjustment systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur;[16] 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,[17] which is over 10 percent of the median family's income that year and over 20 percent of the

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

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

[17] Center for Medicare and Medicaid Services, National Health Expenditure Accounts.

median family's financial assets.[18] 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;[19] pancreatic cancer costs about $57,000;[20] and treatment of a heart attack for 90 days cost over $20,000 in 1998.[21] 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.[22] This amount is 46 percent above median family income and nearly three times the financial assets of the median family. Indeed, the amount -- $85,000 -- exceeds the total financial assets of all but the very well-to-do.[23] Thus, it is very difficult for anyone to commit to paying

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[18] 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.

[19] 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.

[20] *Id*.

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

[22] Kaiser Family Foundation, Trends in Health Care Costs and Spending, March 2009; Agency for Health Care Quality and Research, *supra*, n.15.

[23] Bucks et al., *supra*, n.18.

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.

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")[24] 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.[25]

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[24] 42 U.S.C. § 1395dd.

[25] 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,

Footnote continued on next page

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[26] and are not free to contract over the terms of treatment in the same manner as other buyers and sellers.[27] 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

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Oxford: Cambridge University Press, 1982; Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century, Baltimore: Johns Hopkins, 1999.

[26] *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.

[27] *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).

the patient fires the physician or the physician gives the patient sufficient notice and opportunity to find alternate, sufficient treatment. [28] These requirements for severing the physician-patient relationship apply even if the patient cannot pay for his care.[29]

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 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.[30]

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[28] *See, e.g.*, *Saunders v. Lischkoff*, 137 Fla. 826, 836, 188 So. 815, 819 (1939) (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).

[29] *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).

[30] N. Gregory Mankiw, Principles of Economics, *supra*, n.13.

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

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 is 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.[31]

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 shift" [32] 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[33] and 8.4 percent.[34] 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'

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[31] Agency for Health Care Quality and Research, *supra*, n.15; 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.*

[32] Hadley, *et al., supra*, n.31.

[33] *Id.*

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

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.

Adverse selection causes the premiums for health insurance to increase as a result of a smaller and less healthy pool of insured persons. This price increase causes additional people 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."[35]

[35] 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.

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 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.[36]

In addition, as noted above, 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,

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

preventive, and chronic care and thus become sicker over time.[37] 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.[38] 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.

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

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 various other markets. The combination of the unavoidable need for medical care; the unpredictability of such

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

[38] 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.

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, all combine to create a set of conditions and needs that do not exist in other contexts.

There are clearly other situations in which spreading the cost of a government program across more citizens would ease the burden on some. As others have argued, in light of the Government's financial support for General Motors ("GM"), the 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, and when an individual buys a car, he or she will bear the full cost of that transaction. The GM car hypothetical contrasts sharply with the case of uninsured individuals either receiving uncompensated care or engaging in "market timing" behavior wherein they only pay for insurance when they plan on using medical care or recognize that their medical costs are escalating, and thus inevitably shift costs to other 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. In contrast, as shown above, the costs of much medical care -- especially the most costly care -- occurs unpredictably, the expense cannot be deferred, and the costs are largely borne by others when incurred by an uninsured party.

As several courts have held, 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.[39] 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. [40] The economic characteristics and principles that underlie this conclusion are, however, not common to other markets. As a result, inasmuch as Section 1501 is tailored to address a unique market imperfection arising from characteristics that do not exist in other markets, upholding that necessary corrective measure will not open the

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

[40] *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.*

floodgates of unfettered federal power to require individuals to purchase goods and services or engage in activity that may be good for them.

CONCLUSION

For the reasons set forth above, the Economic Scholars urge the Court to reverse the decision below and instead uphold Section 1501 of the ACA. 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 …."[41] Given the unique economic characteristics of health care, upholding that requirement will not authorize a vast expansion of federal power.

Respectfully submitted,

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March 7, 2011

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[41] *Liberty Univ.*, 2010 WL 4860299, No. 6:10-cv-00015-nkm, at *15.

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the type-face and volume limitations set forth in Federal Rule of Appellate Procedure 32(A)(7)(B) as follows:

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/s/ Richard L. Rosen
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APPENDIX
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CERTIFICATE OF SERVICE

I hereby certify that on March 7, 2011, I filed and served the foregoing Amicus Brief of the Economic Scholars in Support of Appellant with the Clerk of the Court through the CM/ECF system, which will send notice of such filing to the following registered CM/ECF users:

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