No. 11-398

IN THE

Supreme Court of the United States

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Petitioners,

v.

STATE OF FLORIDA, *ET AL.*,

Respondents.

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

BRIEF FOR *AMICI CURIAE* ECONOMISTS IN SUPPORT OF RESPONDENTS REGARDING INDIVIDUAL MANDATE

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

CASES

CONSTITUTION

STATUTES AND RULE

TABLE OF AUTHORITIES
(continued)

Page

OTHER AUTHORITIES

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

INTEREST OF THE *AMICI CURIAE*[1]

The undersigned *amici curiae* ("Economist *Amici*") are 215 economists who have studied, researched, and participated in the national policy discussion relating to the healthcare markets. The Economist *Amici* include Nobel laureates, former senior government officials, and faculty from research universities around the country. The Economist *Amici* support the need for reform but believe that the Affordable Care Act ("ACA" or the "Act") will exacerbate, rather than constrain, the inflation in healthcare costs that poses a serious long-term challenge to the U.S. economy. A complete list of the Economist *Amici* can be found in the Appendix, beginning on page 1a.

Many of the Economist *Amici* filed a brief before the Court of Appeals for the Eleventh Circuit regarding the economic bases on which the Government relies in seeking to defend the ACA's individual mandate as a regulation of interstate commerce, and the Eleventh Circuit relied upon the Economist *Amici*'s analysis in finding the mandate unconstitutional. *See Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1299 & nn.108-111, 113 (11th Cir. 2011).

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[1] No counsel for any party has authored this brief in whole or in part. Several of *amici curiae* are affiliated with the American Action Forum ("AAF"), an independent and nonpartisan research institution, and AAF has made a monetary contribution to the preparation and submission of the brief. Save for AAF, no person other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief. *See* Sup. Ct. R. 37.6. All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court.

Before this Court, many of the Economist *Amici* also have filed briefs in support of Petitioners on the severability question and in support of the State Petitioners on the Medicaid expansion question.

The Economist *Amici* submit this brief in support of Respondents' position that the individual mandate is not authorized by the Commerce Clause because it does not substantially affect interstate commerce. The Economist *Amici* seek to assist the Court in understanding more accurately the statistics relied upon by the Government and the economists who have filed an *amicus* brief supporting the Government (the "Government Economists"). A proper understanding of those statistics reveals 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.

SUMMARY OF ARGUMENT

In section 1501 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), 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 as a measure "necessary and proper for carrying into Execution" the commerce power, *id.* art. I, § 8, cl. 18.

In defending the individual insurance mandate, the Government and its supporting *amici*,

the Government Economists, offer 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 the individual mandate is necessary to address alleged cost-shifting caused by the millions of Americans who voluntarily decide not to participate in the health insurance market—Americans who, by definition, tend to be younger, healthier, and less poor. As an estimate of this cost-shifting problem, the Government cites a figure of $43 billion, which is identified as the total yearly amount of uncompensated medical costs attributable to uninsured persons in the United States. *See* Gov't Br. at 2, 8, 19.

The court below rightly rejected this argument, relying in part on the Economist *Amici*'s analysis showing that "[i]n reality, the primary persons regulated by the individual mandate are not cost-shifters but *healthy individuals* who forego purchasing insurance. The Act confirms as much" through its findings that the individual mandate is required to prevent adverse selection. *Florida*, 648 F.3d at 1299 (emphasis in original). Indeed, "[t]o the extent the data show anything, the data demonstrate that the cost-shifters are largely persons who either (1) are exempted from the mandate, (2) are excepted from the mandate penalty, or (3) are now covered by the Act's Medicaid expansion." *Id.*

The Government's "cost-shifting" justification for the individual mandate, therefore, does not withstand scrutiny because the economic basis for that justification is demonstrably untrue. The individual

mandate has almost nothing to do with cost-shifting in healthcare markets since the population primarily targeted by the mandate (those who can afford health insurance but voluntarily choose not to purchase it because they reasonably expect the cost of insurance to outweigh their foreseeable medical costs) plays a minimal role in the $43 billion of uncompensated costs identified by the Government. As expressly stated in the ACA's findings, the mandate was actually enacted not to stop cost-shifting, but to compel millions of Americans to pay more for health insurance than they receive in benefits in order to subsidize both the voluntarily insured and the insurers, and thereby to mitigate the steep rise in insurance premiums that would otherwise be caused by the ACA itself. The data belie the Government's claim that the individual mandate is constitutional on the ground that it "regulates economic conduct with a substantial effect on interstate commerce." Gov't Br. at 18, 33.

Indeed, neither the Government nor the Government Economists make any serious effort to support the proposition that the individual mandate will come anywhere close to preventing the alleged $43 billion in cost-shifting, nor do they provide any other estimate of the impact that the individual mandate might actually have on any cost-shifting. There is a reason for this. Even taking the Government Economists' various comments on the Economist *Amici*'s methodology into account and incorporating them into the Economist *Amici*'s analysis, as done below, the mandate continues to have only a marginal impact on cost shifting, far below the $43 billion figure the Government summarily asserts.

Before the Eleventh Circuit, the Government also attempted to justify the ACA's unprecedented mandate forcing individuals to participate in the health insurance market on the ground that "health care and health insurance are factually unique and not susceptible of replication due to: (1) the inevitability of health care need; (2) the unpredictability of need; (3) the high costs of health care; (4) the federal requirement that hospitals treat, until stabilized, individuals with emergency medical conditions, regardless of their ability to pay; (5) and associated cost-shifting." *Florida*, 648 F.3d at 1295. In the face of the Court of Appeals' rejection of such an illusory attempt at a limiting principle, the Government now pointedly avoids using the word "unique," even while it defends the mandate based upon the supposedly distinct "realities of the health care services market, and deeply ingrained societal norms" that purportedly differentiate healthcare markets from other markets. Gov't Br. at 39; *see also id.* at 40.

The Government Economists, less daunted by the decision below, persist in labeling the healthcare industry "unique," because of its high rates of participation, high costs, federal mandates, and the purported uncertainty surrounding the need for care. Econ. Br. at 2, 3, 6-21. This emphasis on the "uniqueness" or the distinctiveness 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. *See, e.g.*, *id.* at 18-21.

But the healthcare market is "unique" only in the sense that each snowflake is unique. The economic features relied upon by the Government are not unique to health care, but are characteristic of many markets and cannot—whether taken together or separately—provide defensible limits to Congress's power under the Commerce Clause. Indeed, frequently, the cost-related externalities cited by the Government are not even intrinsic to the healthcare market, but rather reflect distortions caused by federal law. Accordingly, these features can serve neither as a justification for expanded federal regulation nor as a genuine limiting principle for the assertion of federal authority represented by 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 fairly attributable to the targeted population are no more than around $12.8 billion, or *one-half of one percent* of the Nation's $2.4 trillion in annual healthcare costs. *See* Appendix at 27a. 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 Eleventh Circuit cited this economic analysis in finding the individual mandate unconstitutional. *See Florida*, 648 F.3d at 1299 & nn.108-111, 113. The Government did not challenge this analysis either below or in its opening brief before this Court concerning the individual mandate. *See, e.g.*, Gov't Br. at 2, 8, 19. In its severability brief before this Court, however, the Government adopts the arguments of the Government Economists and takes issue with the Eleventh Circuit's conclusions regarding the effects of the mandate. *See* Gov't Br. (Severability) at 53-54 (citing Econ. Br. at 25-29). For instance, the Government Economists claim that the numbers should use a formula that more clearly excludes legal immigrants, who are not exempt as a class from the mandate. In addition, they contend that the $43 billion figure should not include any uncompensated costs imposed by the insured.

Tellingly, neither the Government Economists nor the Government attempts to provide an alternative to the Economist *Amici*'s analysis. This omission is explained by the fact that even when the Government Economists' suggestions are incorporated into the analysis, the cost figures associated with the target population increase only modestly and still do not approach the $43 billion number relied upon by the Government. At most, the individual mandate potentially affects only a small fraction of the $43 billion figure that the Government and its *amici* trumpet—well under one percent of the total healthcare market. This realization helps to confirm that the asserted cost-shifting rationale offered by the Government is pretextual and that the real purpose of the mandate is to force younger and healthier indiv-

iduals to subsidize the higher costs of health insurance that will be caused by the Act itself.

The Government further fails to show that "average" Americans cannot afford their own healthcare costs and thus the uninsured must *ipso facto* contribute to cost-shifting. While the Government Economists emphasize the approximately $6,300 in healthcare costs incurred by *the average* American per year, they provide no analysis of the costs actually paid by those subject to the mandate. In fact, the undisputed data show that the young, healthy, and uninsured, who are the real 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 guaranteed-issue and community-rating provisions." Gov't Br. at 18.

The ACA prevents health insurers from making the basic actuarial decisions that they make in every other insurance market. Insurers may no longer withhold health insurance from those with preexisting conditions or 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 terms that are economically disadvantageous.

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 "how health care consumption is financed," Gov't Br. at 17, but to compel the voluntarily uninsured to purchase insurance at disadvantageous prices, as a quid pro quo to existing health insurance market participants in exchange for the deleterious effect of new federal requirements. Thus, as the Court of Appeals recognized, "[p]roperly formulated, . . . [the question presented is] whether the federal government can issue a mandate that Americans purchase and maintain health insurance from a private company for the entirety of their lives." *Florida*, 648 F.3d at 1287. As that court correctly noted, the Government has provided no constitutionally principled limitation on the federal government's power if such a mandate is upheld. *See id.* at 1295-97 & nn.101-03; *cf. United States v. Lopez*, 514 U.S. 549, 563-68 (1995).

2. Recognizing the unprecedented exertion of federal authority, and the absence of any true limiting principle, the Government Economists argue that the healthcare industry is "unique" and thus that this Court need not be concerned that upholding the individual mandate will remove any practical limit to Congress's commerce power. This "uniqueness" 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. Gov't Br. at 18-19. Most strikingly, the Government contends that the individual mandate is necessary to address more than $43 billion in annualized healthcare costs that the uninsured do not pay. *Id.* at 8, 19. 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 Government Economists further explain:

> [t]he collective effect of individual decisions not to purchase health insurance . . . . affects health insurance premiums, the coverage insurance companies can provide at reasonable rates, and the extent to which the costs of caring for the uninsured *are borne by others*, including the taxpayer. As noted above, *the total costs of uncompensated care in 2008 alone were at least $43 billion* . . . .

Econ. Br. at 24 (emphasis added); *see also id.* at 19 ("[T]he costs incurred by the uninsured are largely borne by others."). The problem with this story is that it is untrue. As a matter of basic economics, the individual mandate has little to do with the alleged $43 billion of uncompensated costs the Government cites. Instead, the mandate is designed to subsidize the dramatic cost increases that the Act itself would otherwise impose on health insurers.

While the Government and its supporting economists take issue with elements of the Economist *Amici*'s analysis, they do not and cannot dispute that the $43 billion figure to which the Government clings is a grossly inflated estimate of any effect the individual mandate might have on uncompensated care. Indeed, before this Court, the Economist *Amici* have incorporated some of the Government Economists' comments, as described below. Even after doing so, the conclusion remains the same: As the

Eleventh Circuit correctly held, the individual mandate would have a minimal impact on the uncompensated care that the $43 billion figure represents. The mandate therefore does not truly address any asserted cost-shifting problem and cannot be upheld on that basis.

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 individual mandate is justified because "the uninsured as a class," Gov't Br. at 19, impose $43 billion on the rest of the economy lacks any support. In fact, only a small fraction of the uninsured—and therefore only a fraction of the costs of uncompensated care—are directly affected by the mandate.

The individual mandate, by definition, targets people who could but *choose* not to purchase health insurance and who will not otherwise be covered by Medicaid or Medicare. These people tend to be younger and healthier.[2] These citizens make the rational economic decision to pay for their relatively modest healthcare expenditures out of pocket, rather than purchasing insurance. Indeed, if they needed health insurance at all, they would require only the relatively inexpensive insurance limited to covering

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[2] *See* Jack Hadley et al., *Covering the Uninsured in 2008*, Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation 60 (Aug. 2008), *available at* http://kff.org/uninsured/upload/7809.pdf.

catastrophic care, a market now foreclosed by the ACA.[3]

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 the discounted prices negotiated by insurance providers.[4]

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[3] Under the ACA, insurers may offer catastrophic coverage plans to those under 30 and other individuals who qualify for certain exemptions under the Act, but even such "catastrophic" plans are far from the plans in the market today that are aimed only at large, truly unexpected expenses: They must still provide "essential health benefits" coverage, as defined under the Act, after a certain threshold has been met, and must also provide for "at least three primary care visits." 42 U.S.C. § 18022(e); *see also Florida*, 648 F.3d at 1255 (describing this modified catastrophic coverage).

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

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,[5] which comprises data from "large-scale surveys of families and individuals, their medical providers, and employers," and is the most complete source of data on healthcare expenditures in the United States.[6] MEPS is collected and maintained under the auspices of the U.S. Department of Health and Human Services.[7]

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*.[8] As the CBO has

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[5] *See* Families USA, *Hidden Health Tax: Americans Pay a Premium* 1, 2 (2009), http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf (other pages of this source cited by Gov't Br. at 7, 8).

[6] Medical Expenditure Panel Survey ("MEPS"), U.S. Dep't of Health & Human Servs., http://www.meps.ahrq.gov/mepsweb (last visited Feb. 12, 2012).

[7] *Id.*

[8] Centers for Medicare & Medicaid Services ("CMS"), National Health Expenditure Projections 2010-2020, at Table 1 (2011), *available at* https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf.

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."[9] Thus, even if accurate, the $43 billion in uncompensated care still represents less than 1.8 percent of the overall market.

Even that 1.8 percent, however, is quite misleading because it represents *the totality* of uncompensated care attributable to the uninsured in the healthcare system, not the costs specifically associated with those who are *voluntarily* uninsured and either not exempt from the mandate or not likely to become insured as a result of *other* provisions of the ACA. Indeed, the MEPS data reveal that the actual portion of uncompensated care attributable to those targeted by the individual mandate is vastly smaller, and in fact constitutes less than one-half of one percent of the overall market for health care.

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,[10] as follows:

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[9] CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 13 (Nov. 30, 2009), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf [hereinafter *Premiums*].

[10] The Economist *Amici*'s methodology is explained in the Appendix, beginning at page 21a. These figures reflect weighted estimates based on provider recovery rates (*i.e.*, the amount that providers typically recover after treatment). The Appendix 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).

- *Medicaid Recipients*. An estimated $18.0 billion of the $43 billion reflects care rendered to cost-shifters who are now newly eligible for Medicaid based on the Act's expansion of Medicaid to all individuals and households whose income is at or below 133 percent of the poverty line;[11]

These numbers differ in components from those advanced by the Economist *Amici* before the Eleventh Circuit, largely because they incorporate comments from the Government Economists. In particular, the Government Economists have challenged the exclusion of lawful permanent residents from the uncompensated costs, as well as the uncompensated costs associated with persons who do have health insurance. *See* Econ. Br. at 27-28. The Government Economists have also argued that the baseline population should not be the young, healthy and uninsured, but the healthy and uninsured up to the age of Medicare. *Id.* at 14 n.39.

Because the Government Economists' comments do not significantly alter the model's conclusions, the Economist *Amici* have elected simply to incorporate them into the model, thereby refining the model and minimizing any distracting disputes over the appropriate assumptions. Thus, the Economist *Amici* have adopted a narrower definition of illegal immigrants based on that employed in the scholarly journal cited by the Government Economists, *see id.* at 27 n.73, excluded from the analysis the uncompensated costs from those with health insurance, and taken as the baseline the healthy and uninsured up to the age of Medicare. In addition, the Economist *Amici* have refined their methodology to compare total costs for various populations rather than per capita costs (resulting in more precise numbers where per capita costs vary), and to eliminate overlap to ensure that the costs associated with persons who may fall into more than one of the above categories are not counted twice.

[11] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Most or all of those with income at or below 133 percent of the poverty line will also be exempt from the penalty that is tied to mandate,

- *Illegal Immigrants.* Of the remaining $25 billion, roughly $1.3 billion is attributable to uncompensated care provided to illegal aliens, who will not be subject to the mandate at all;[12] and
- *Preexisting conditions.* From the remaining $23.7 billion, an additional $7.7 billion must be subtracted for uncompensated care rendered to non-Medicaid-eligible, non-illegal immigrant 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.[13]

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though not the mandate itself, under the exemption for those "who cannot afford coverage," 26 U.S.C. § 5000A(e)(1), and/or the exemption for those who do not file a tax return. *See* 26 U.S.C. § 5000A(e)(2).

[12] 26 U.S.C. § 5000A(d)(3) ("[i]ndividuals not lawfully present" not included in those subject to the mandate).

[13] 42 U.S.C. § 300gg-3. The Government Economists further claim that the analysis should not subtract the entirety of those with chronic conditions, *see* Econ. Br. at 26, but the Government itself argues that most of the uninsured would buy coverage if it were more affordable, Gov't Br. at 44. While it is certainly possible that some with chronic conditions might fail to purchase insurance, it is reasonable to assume that given the guaranteed issue and community rating provisions, an overwhelming number of those individuals will make the economically rational choice to do so (since their healthcare costs would exceed the community-rated premiums), and the Government Economists propose no alternative methodology for determining that number more precisely.

Taking those numbers into account, the *maximum* share of uncompensated care attributable to the mandate's target class would be approximately $16 billion, a far cry from $43 billion.[14]

Yet that number remains over-inclusive because it counts the costs of uncompensated care for those who, despite the law, will not comply with the mandate. The CBO estimates that four million of the currently uninsured who are subject to the penalty linked to the mandate will nonetheless not purchase health insurance when the mandate comes into effect.[15] Accordingly, an appropriate measure of the mandate's impact must exclude the uncompensated costs from those who fail to comply with the mandate.

The Economist *Amici* have estimated that figure by determining that, according to the MEPS data, approximately 17.3 million people are uninsured, healthy, over 133 percent of the poverty line, and not undocumented aliens. The CBO estimates that 90%

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[14] This analysis is consistent with a recent study of California's healthcare system, which concluded that "[c]ost shifting from the uninsured is minimal" and is far outweighed by cost shifting attributable to patients covered by government insurance programs. Daniel P. Kessler, *Cost Shifting in California Hospitals: What Is the Effect on Private Payers?*, California Foundation for Commerce and Education 1 (June 6, 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.

[15] CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* (Apr. 22, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11355/Individual_Mandate_Penalties-04-22.pdf [hereinafter *Penalties*].

percent of those who pay the penalty will have incomes over the poverty line and 75% will have incomes more than twice the poverty line.[16] Those figures are unsurprising given that the healthy and those not eligible for Medicaid are far more likely to make the rational decision to pay the penalty tied to the mandate rather than pay for health insurance. Thus, roughly 80% of those who pay the penalty rather than comply with the individual mandate are likely to be uninsured, healthy and over 133 percent of the poverty line. As a result, the $16 billion figure—which represents the maximum possible reduction in uncompensated care fairly resulting from the mandate—should be further reduced by approximately 20 percent to account for the continued uncompensated care rendered to the voluntarily uninsured who do not comply with the mandate. Thus, the individual mandate will actually have an impact on no more than $12.8 billion of the total $43 billion figure, and this small fraction represents only one-half of one percent of total annual healthcare spending in the United States.[17]

Accordingly, the voluntarily uninsured, who choose to pay their own relatively modest healthcare costs out of pocket, plainly cannot be described as villains who impose significant uncompensated costs on others. The actual amount of cost-shifting fairly at-

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[16] *Id.* at 2.

[17] Indeed, the true number is lower still, because even without the mandate, the Act's subsidies would induce an additional population from among those currently uninsured to become insured. Excluding the uncompensated costs associated with such individuals would further reduce the actual projected effect of the mandate on uncompensated care.

tributable to the class of uninsured targeted by the mandate is, in truth, only a small fraction of the $43 billion in total uncompensated costs cited by Congress, and it cannot reasonably justify the legislative decision to enact 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," Gov't Br. at 35, and frequently expensive, *see id.* at 8, 19. The Government Economists offer some specifics. They claim that the "average person" in 2007 used $6,305 in "personal health care services," which is "over 10 percent of the median family's income." Econ. Br. at 8. The Government too emphasizes how this costliness renders the payment of medical bills without insurance so difficult that the mandate is a necessary part of the effort to forestall the inevitable cost-shifting. *See* Gov't Br. at 8, 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. 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 at the "average" American in the healthcare market. It is meant to address adverse selection, and it is directed at younger, healthier individuals who, in the absence of such a mandate, would make an economically rational choice to forgo health insurance. *See* Gov't Br. at 29 n.6 (quoting 42 U.S.C. § 18091(a)(2)(I)); Econ. Br. at 16. As might be expected, this class consumes only a fraction of the national average in healthcare services per year. In fact, in 2010, the young, healthy, and voluntarily uninsured consumed, on average, only $854 in healthcare services, approximately 14 percent of the claimed "average" healthcare expenditure. *See* Appendix at 22a. 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.[18] *Cf.* Econ. Br. at 8. 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 Government Economists 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 young and healthy targets of the mandate

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[18] In 2007, the average household earned roughly $84,000. *See* Brian K. Bucks et al., *Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances*, Federal Reserve Bulletin, Feb. 2009, A5, *available at* http://www.federalreserve.gov/pubs/bulletin/2009/pdf/scf09.pdf.

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, and paid by, patients) and the more routine care administered there. *See* Appendix at 22a. The data thus provide 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.

The Government Economists argue that even if the average costs to the young, healthy, and uninsured are small, the expenses for such persons who do incur costs may be higher. *See* Econ. Br. at 9 (citing, for instance, $7,933 as the average in-hospital cost for a normal live birth and tens of thousands of dollars as the cost of treating ailments like colorectal cancer, pancreatic cancer, and heart attacks). Those numbers are surely larger than the average per capita cost. But the Government Economists provide no information about how many uninsured people actually *experience* such health events, nor how many fail to pay those costs. Moreover, such an argument points towards requiring insurance for catastrophic costs, not for routine healthcare expenditures. *See infra* at 30-31.

In addition, the Government Economists claim that it is wrong to consider the average costs of the young, healthy, and uninsured, rather than simply the healthy and uninsured, without regard to age. *See* Econ. Br. at 14 n.39. They instead estimate $2,000 in costs per year for the average uninsured person. *Id.* at 14. Notably, that $2,000 annual figure is a far cry from the $6,305 in average expendi-

tures they had previously relied upon. And using an average figure for the uninsured fails to account for the costs incurred by those exempted from the mandate or the penalty, including illegal immigrants and those below the income threshold.

Even so, the young, healthy, and uninsured are the appropriate population to examine in order to understand the costs incurred by the core group that Congress found "would make an economic and financial decision to forego health insurance coverage" in the absence of the mandate. 42 U.S.C. § 18091(a)(2)(A); *see also id.* § 18091(a)(2)(I) ("[I]f there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.").[19]

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[19] As discussed *supra*, the Economist *Amici* did accept the Government Economists' suggestion that when allocating the $43 billion in the total uncompensated costs of the uninsured, the relevant analysis should consider the costs to the healthy and uninsured, without respect to age. That is different from here, where the question concerns the average annual healthcare costs faced by the population most likely to choose voluntarily to remain uninsured. But even if the average healthcare costs of the uninsured population that is healthy, over 133 percent of the poverty line, and not an undocumented alien were considered, that sum would be $1,652, *see* Appendix at 22a, barely one-quarter of the $6,305 figure cited by the Government Economists. *See* Econ. Br. at 8.

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 premiums). The Government itself acknowledges that the individual mandate "is key to the viability of the Act's guaranteed-issue and community-rating provisions." Gov't Br. at 18.[20]

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

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[20] 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 tied to 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; CBO, *Penalties*, *supra* note 15 (estimating that 4 million people subject to the mandate and not exempt from the penalty will nonetheless fail to buy health insurance), and the Act liberally excuses individuals from the penalty associated with the mandate based on hardship, *see* 26 U.S.C. § 5000A.

otherwise 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 before other offsetting reductions including those due to the individual mandate, the ACA's insurance reforms would cause costs for health insurance in the individual market to rise 27 to 30 percent over current levels in 2016.[21]

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 likely

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[21] CBO, *Premiums*, *supra* note 9, at 6 (cited by *Florida*, 648 F.3d at 1298 n.107).

receive in benefits. By 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 otherwise caused by the ACA.

The CBO estimates that the individual mandate will have the effect of reducing premiums for those currently insured by choice between $28 and $39 billion in 2016 alone.[22] In other words, those 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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[22] CBO, *Premiums*, *supra* note 9, at 5, 6; CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf; *see also* Private Pet'rs' Br. at 3 (citing Private Pet'rs' Br. (Severability) at 14 & n.15).

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 Economists argue that the economics of the healthcare industry are "unique" and therefore warrant an unprecedented expansion of Congress's Commerce Clause authority. *See* Econ. Br. at 2, 3, 6-21. The Government, while avoiding that phrase before this Court, still argues based on the "realities" of the supposedly distinct healthcare market. Gov't Br. at 19; *see also Florida*, 648 F.3d at 1295-98 (rejecting the Government's "uniqueness" argument). 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 Government Economists 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 18-21. 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," Gov't Br. at 35, and "unavoidable," Econ. Br. 3, 18, 20. 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 de-

mand 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.[23] 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* Gov't Br. at 19; Econ. Br. at 3, 6, 18-20. 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 federal intervention in the healthcare insurance market.

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[23] 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(b)(1).

In fact, however, the routine costs of care for most people are fairly predictable. The average expenditures per year per person are calculated and published with regularity.[24] 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—as the Government Economists implicitly concede, *see* Econ. Br. at 9—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(b)(1) (definition of "essential health benefits"), 18022(e) (restrictions on catastrophic plans); *see also supra* note 3 (describing the

[24] *See, e.g.*, CMS, National Health Expenditure Projections 2010-2020 (2011), *available at* https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf.

limited catastrophic insurance plans that the ACA would permit). 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 to regulate the healthcare market because the risk of catastrophic loss is unpredictable suffers from the absence of any limiting principle. *See Florida*, 648 F.3d at 1296 ("Under the government's proposed limiting principles, there is no reason why Congress could not similarly compel Americans to insure against any number of unforeseeable but serious risks."); *see also id.* at 1295-98 & n.103).

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 Government Economists contend that health care is unique "[b]ecause medical care is so expensive [that] the majority of individuals receiving care require funds beyond their own resources in order to afford it." Econ. Br. at 8; *compare* Econ. Br. before Eleventh Circuit at 11 ("*essentially everyone* must have some access to funds beyond their own resources in order to afford" medical care (emphasis added)). 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 of all consumers of health care or of all uninsured with the much lower costs of those voluntarily uninsured who will not be exempt from the mandate. 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 certain 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 three percent of the total healthcare market, and only about half of that care goes uncompensated.[25] Thus,

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[25] *See* American College of Emergency Physicians, *Costs of Emergency Care*, http://www.acep.org/content.aspx?id=25902 (last visited Feb. 11, 2012).

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-Respondents 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 Resp'ts' Br. at 43-46.

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.*, *Kentucky v. King*, 131 S. Ct. 1849, 1858 (2011). 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). 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, 150-52, 188 (1992). These cases recognize the common-sense 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 of 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 emer-

gency 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) ("'[T]he 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.'" (quoting *New York*, 505 U.S. at 187)). Even so, the Court of Appeals' 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 health care market" that the Government describes, Gov't Br. at 2, 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.[26]

As the Government and its *amici* emphasize, the individual mandate is a policy that was first adopted in certain States, such as Massachusetts. *See, e.g.*, Gov't Br. at 16, 30. 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.[27]

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[26] Several non-Plaintiff States have filed an *amicus* brief supporting the Government arguing, inter alia, that States are curtailed in their ability to effect healthcare reform because insurers or residents might leave for neighboring States if they dislike a new reform. *See* State *Amici* Br. at 20-23. But, once again, this provides no limiting principle, as individuals and businesses are always free to leave a State that institutes a policy that will be costly to those individuals, for instance a dramatic tax increase. That does not mean Congress has the power to interfere with States' tax rates, nor does the portability across state lines of healthcare providers and insurers make Congress's attempted conscription of *non*-consumers of insurance constitutional.

[27] For a comprehensive survey of state healthcare reform legislation, see, for example, John E. McDonough, et al., *A Progress Report On State Health Access Reform*, 27 Health Affairs w105 (Jan. 29, 2008), http://content.healthaffairs.org/content/27/2/w105.full.pdf+html; *see also* Amy M. Lischko & Anand Gopalsami, *An Interim Report Card on Massachusetts*

Although many States have made this case in challenging the individual mandate, several have filed an *amicus* brief supporting the Government. In support of the Government's position, State *Amici* argue that the ACA is a blueprint for model cooperation between the federal government and the States. *See, e.g.*, State *Amici* Br. at 29-36. This portrayal ignores the unconstitutionally coercive Medicaid expansion the Act foists on States, as well as the fact that the ACA imposes a particular purported solution—the individual mandate and associated insurance reforms—to attempt to solve a complex problem that States have attempted to address in diverse ways. 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 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.

Heath Care Reform, Part 1: Increasing Access, A Pioneer Institute White Paper, Jan. 2010, at 12, http://www.pioneerinstitute.org/pdf/100113_interim_report_card1.pdf (concluding that "the reform has been successful at insuring more Massachusetts residents"); State of Illinois, *Healthcare for All Kids*, http://www.allkidscovered.com (last visited Feb. 13, 2012) (guaranteeing health insurance to all children in the Illinois).

CONCLUSION

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

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Appendix

METHODOLOGY OF STATISTICAL ANALYSIS

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

- **Spending by the Young, Healthy, and Uninsured:** 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 pressure)
  - 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 healthcare costs of 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

Additionally, the Economist *Amici* calculated the population and total costs associated with the healthy and uninsured who were not under 133 percent of the federal poverty level, nor undocumented aliens. The aggregate health spending for that population of 17,268,000 was $28,535,000,000. The average healthcare costs of this class may be expressed as:

($28,535,000,000) / (17,268,000) = $1,652

The aggregate emergency room spending for this population was $1,553,000,000. Thus, the average costs of emergency care are:

($1,553,000,000) / (17,268,000) = $90

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

  First, the following subsets of the total population of patients who had no insurance when

their healthcare provider billed them were identified from the MEPS dataset:

- Undocumented aliens;[1]
- Individuals or households earning less than 133 percent of the federal poverty level and who were not undocumented aliens;
- Individuals with previously existing conditions who earned more than 133 percent of the federal poverty level and were not undocumented aliens; and
- Healthy individuals who earned more than 133 percent of the federal poverty

[1] Because MEPS does not directly track survey participants' immigration status, estimating the costs associated with undocumented aliens requires applying certain assumptions. In response to the Government Economists' objection that the Economist *Amici* should use a measure that excludes legally resident immigrants, the Economist *Amici* recalibrated their method of attempting to isolate illegal immigrants, in part using the methodology suggested by the article relied upon by the Government Economists (even though that methodology may well understate the uncompensated costs imposed by illegal immigrants). *See* Econ. Br. at 27 & n.73 (citing Leighton Ku, *Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States*, Am. J. of Pub. Health, July 2009, at 1322-28). The Economist *Amici* also drew from estimates of the illegal immigrant population in Pew Research Center for the People & the Press and Pew Hispanic Center, *No Consensus on Immigration Problem or Proposed Fixes: America's Immigration Quandry* (Mar. 30, 2006), http://peoplepress.org/reports/pdf/274.pdf.

level and were not undocumented aliens.[2]

These data yielded the following unweighted findings:

Population	**Uncompensated Care $ (millions)**	**Percentage of $43 billion**
Undocumented aliens:	$1,283	3.0%
Less than 133% of the poverty line, not undocumented aliens:	$16,154	37.6%
Previously existing condition, more than 133% of poverty line, not undocumented:	$10,367	24.1%
Healthy, more than 133% of poverty line, not undocumented:	$15,196	35.3%
TOTAL	~$43,000	100%

[2] To ensure that these populations encompassed all uninsured individuals but did not double-count any individuals, the Economist *Amici* eliminated overlap (*i.e.*, costs associated with persons who fell into more than one category). This procedure could have been done in a different order, but the ultimate conclusion regarding the cost of care rendered to those subject to the mandate—the healthy, non-poor, non-undocumented—would remain the same.

The raw data thus establish about $15.2 billion in uncompensated costs for the target category. Population-specific recovery rates then were calculated for each sub-population based on market data in Stephen T. Parente, *Health Information Technology and Financing's Next Frontier: The Potential of Medical Banking*, 44 Bus. Econ. 41 (Jan. 2009). The weighted recovery rates are as follows, along with the adjusted yield by population:

Appendix

Population	Adjusted Recovery Rate	Adjusted Uncompensated Care $ (millions)	Percentage of $43 billion
Undocumented aliens:	0.2	$1,272	3.0%
Less than 133% of the poverty line, not undocumented aliens:	0.1	$18,015	41.9%
Previously existing condition, more than 133% of poverty line, not undocumented:	0.4	$7,708	17.9%
Healthy, more than 133% of poverty line, not undocumented:	0.15	$16,005	37.2%
TOTAL		~$43,000	100%

The approximately $16 billion in adjusted uncompensated costs from the healthy, non-poor, non-undocumented, and uninsured can be expressed as a

percentage of the overall healthcare market of $2.4 trillion as:

($16,000,000,000) (100) / ($2,400,000,000,000) = 0.67%

In addition, because approximately 4 million people are projected to be subject to the mandate yet to remain uninsured, the amount of uncompensated care that is likely to be affected by the mandate must be further reduced by approximately 20% (rounding down from 4 million divided by the 17.3 million people in the final category in the charts above), *see supra* at 18-19, to roughly $12.8 million, which can be expressed as a percentage of the overall health-care market of $2.4 trillion as:

($12,800,000) (100) / ($2,400,000,000,000) = 0.53%