RECORD NO. 11-1057

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,

v.

KATHLEEN SEBELIUS, SECRETARY OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
IN HER OFFICIAL CAPACITY,

Defendant-Appellant.

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

BRIEF OF *AMICUS CURIAE* VIRGINIA ORGANIZING
IN SUPPORT OF APPELLANT

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March 7, 2011

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
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Robert Avery, Paul Calem, Glenn Canner, & Raphael Bostic, *An Overview of Consumer Data and Credit Reporting*, Fed. Reserve Bulletin, at 69 (Feb. 2003), *available at* http://www.federalreserve.gov/pubs/bulletin/2003/0203lead.pdf. 7

State Health Facts, *Health Insurance Coverage of the Total Population*, http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3 (last visited Mar. 4, 2011).. 2, 3

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Virginia Hosp. & Healthcare Assoc., *Community Benefit Report* 2008 (2008), http://www.vhha.com/_uploads/documents/live/09CommunityBenefitReport.pdf?CFID=47078047&CFTOKEN=45303050. 5

Amicus Curiae, Virginia Organizing, files this brief in support of Appellant, Kathleen Sebelius, Secretary of the Department of Health and Human Services. *Amicus* supports reversal of the District Court's decision.

INTERESTS OF *AMICUS CURIAE*

Virginia Organizing, a statewide organization with over 8,000 members, works to empower Virginians who traditionally have had little or no institutional voice to work democratically for change.[1] Access to health care is one of the major issues Virginia Organizing has identified as facing its members and other citizens in their communities. Virginia Organizing continues to work on improving access to health care for moderate and low income Virginians. In 2008 and 2009, Virginia Organizing canvassed over 300,000 households across the state and gathered information about problems facing health care consumers in Virginia. Over 70% of those surveyed favored major health care reform. Hundreds of the Virginians surveyed reported struggling with debt from health care expenses.

A major commitment of Virginia Organizing is to educate the public about the Patient Protection and Affordable Care Act, ("ACA"),

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[1] Pursuant to Federal Rule of Appellate Procedure 29(c) (5), counsel for *Amicus* represents that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *Amicus,* its members or it counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this *amicus* brief, pursuant to Federal Rule of Appellate Procedure 29(a).

Pub. L. No. 111-148, 124 Stat. 119 (2010). Its members are already benefiting from the ACA: young adults up to age twenty-six have returned to their parents' health insurance policies, uninsured adults have accessed the new high-risk pool, and children have obtained insurance without regard to their pre-existing conditions. Virginia Organizing members have an interest in keeping those benefits and in accessing the additional reforms and improvements contained in the ACA legislation.

STATEMENT OF FACTS

A. Virginians Who Consume Health Care Services Participate in an Interstate Market.

Amicus presented the following as undisputed supplemental facts in its brief below, and they remain undisputed. Virginians experience the same challenges in paying for their health care as Appellant describes on a national level.

Although Virginia ranks in the top 10 in wealth among the states, it ranked twenty-ninth in the percentage of insured population from 2007-2008. *Virginia Compared to Other States,* Joint Legislative Audit and Review Commission, 2010 Edition, Table 3, *available at* http://jlarc.state.va.us/states/t3.pdf; State Health Facts, *Health Insurance Coverage of the Total Population*, http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3 (last visited Mar. 4, 2011). Approximately one million Virginians have been uninsured during each of the past three years. Allison Cook, Genevieve Kenney & Emily Lawton,

Profile of Virginia's Uninsured and Trends in Health Insurance Coverage, 2000-2008 ("*Profile*"), The Urban Institute, 2, Jan. 2010, http://www.vhcf.org/wp-content/uploads/2010/10/Profile-of-Uninsured-in-VA_final_Jan2010.pdf.

While many Virginians are fortunate to obtain health insurance from their employers, the percentage of Virginians under age 65 who get health insurance at work has declined over the last decade, dropping from 71.6% in 1999 to 65.7% in 2009. U.S. Census Bureau, *Health Insurance Historical Tables,* Table HIA-6, http://www.census.gov/hhes/www/hlthins/data/historical/index.html (last visited Mar. 4, 2011). Moreover, the cost of that insurance has skyrocketed and employees are shouldering more and more of the costs. Virginians pay a higher percentage of employer-based insurance premiums than workers in any other state. *Medical Expenditures Panel Survey*, Agency for Healthcare Research and Quality, 2008. *Id.*

The consequences of being uninsured as well as incurring high out-of-pocket costs can be dangerous and even life threatening. Over 782,000, or 13% of all Virginians, could not see a doctor in 2009 because of costs. State Health Facts, *Health Insurance Coverage of the Total Population*, http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3 (last visited Mar. 4, 2011).

Marcus A. Grimes, a member of Virginia Organizing, was diagnosed with diabetes at age 18. Working as a teacher in a charter school in Washington, D.C, he could not afford the high cost of an individual policy: $627 every two week pay period. He worked out five or six days a week, adhered to a healthy diet and eliminated the need for insulin. Despite those efforts, problems with his vision required a $50,000 surgical procedure which he could not afford. Mr. Grimes lost both his vision in 2004 and his ability to work as a teacher as a direct result of his lack of money or health insurance to obtain necessary surgery. Now totally blind, he has never seen his wife's or daughters' faces. He cannot drive. Instead of contributing to society by helping students learn, he is dependent on a Social Security check each month.

Virginians who cannot afford the costs of treatment forego necessary health care or seek health care from overburdened health clinics or emergency rooms. These gaps in coverage contribute to an annual burden of uncompensated care that in Virginia amounted to $1.45 billion in 2005. *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*, Joint Legislative and Audit Review Commission, HD 19 (2007), p.37, http://jlarc.state.va.us/reports/Rpt349.pdf. This continuing burden was confirmed in Virginia Health Information, *Industry Report*, http://www.vhi.org/industry_reports.asp (last visited Mar. 4, 2011) that reported

Virginia hospitals provide more than $1.4 billion dollars annually in uncompensated care to patients, nearly 4% of gross patient revenue.

Three Virginia hospital systems provide over 25% of their inpatient care to Medicaid patients and the uninsured: 42.9% at VCU Health System; 28.5% at UVA; and 27.3% at Carilion. Sheldon M. Retchin, CEO, VCU Health System, Presentation to Virginia Senate Finance Subcomm. on Health and Human Resources: Impact of Health Care Reform on Virginia's Academic Medical Centers, slide 11 (Aug. 24, 2010), http://sfc.virginia.gov/pdf/health/2010%20SEssion/August24%20Jt%20Mtg/No5VCU.pdf, slide 11.

Virginia hospitals admitted 81,000 uninsured patients in 2008 and incurred $419 million in bad debt expenses. Virginia Hosp. & Healthcare Assoc., *Community Benefit Report* 2008 (2008), http://www.vhha.com/_uploads/documents/live/09CommunityBenefitReport.pdf?CFID=47078047&CFTOKEN=45303050. Examples of bad debt expenses reported by Richmond-area hospitals for 2007-2008 are:

- Bon Secours Memorial Regional Medical Center - $13,621,211
- Bon Secours St. Mary's Hospital - $16,087,200
- Henrico Doctors Hospital - $26,826,945
- John Randolph Medical Center - $15,209,183
- Southside Regional Medical Center - $18,876,869
- VCU Health System - $124,716,149
- CJW Medical Center - $45,138,015

Id.

B. The Costs of Uninsured Medical Care Become Part of the Secondary Interstate Markets for Consumer Credit and Debt Financing.

When an uninsured person fails to pay a medical provider, she or he incurs medical debts which the provider usually seeks to collect. These medical debts become a part of the secondary markets for consumer credit and debt financing. Medical debt has severe consequences for financial stability. Nationally, about 29 million adults have medical debt, and even relatively small levels of medical debt can have major consequences on financial security. Cindy Zeldin & Mark Rukavina, Demos: The Access Project, *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses*, 1-3, http://www.accessproject.org/adobe/borrowing_to_stay_healthy.pdf (last visited Mar. 4, 2011). Lapses in health insurance are strong predictors of medical debt. *Id.*

In 2007, 41% of adults reported that they had medical debt or trouble paying medical bills, up from 34% in 2005. Press release, The Commonwealth Fund, *Second National Scorecard on U.S. Health Care System Finds No Overall Improvement; Steep Decline in Access, Scores on Efficiency Especially Low* (July 17, 2008). http://www.commonwealthfund.org/~/media/Files/News/News%20Releases/2008/Jul/Second%20National%20Scorecard%20on%20U%20S%20%20Health%20Care%20System%20Finds%20No%20Overall%20Improvement%20%20Steep%20Dec

line%20in/Scorecard08releaseFINAL_7%2014%2008%2002%20.pdf.

One study estimates that 62% of all bankruptcies have a medical cause, and the share of bankruptcies attributable to such causes increased by 50% between 2001 and 2007. David U. Himmelstein *et al., Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 Am. J. of Med. 741, 742 (2007). This affects both the uninsured and consumers whose health insurance does not cover necessary care because of preexisting condition restrictions, limits on services, caps on coverage, and out of pocket expenses. In 2003, 40% of bankruptcy filings involve a medical debt of over $5,000; 13% involve medical debt of over $10,000. BCS Alliance, *Bankruptcy and Medical Debt*, http://www.bcsalliance.com/y_debt_medical.html (last visited Mar. 4, 2011). In 2009, 35,338 non-business bankruptcies were filed in Virginia. American Bankruptcy Institute, *Annual Business and Non-business Filings by State*, http://www.abiworld.org/AM/AMTemplate.cfm?Section=Home&CONTENTID=63179&TEMPLATE=/CM/ContentDisplay.cfm (last visited Mar. 4, 2011).

Medical debts that show up on credit reports pose a difficult and unfair quandary for consumers. A study by Federal Reserve researchers found that 52% of all accounts reported by collection agencies consisted of medical debt. Robert Avery, Paul Calem, Glenn Canner, & Raphael Bostic, *An Overview of Consumer Data and Credit Reporting*, Fed. Reserve Bulletin, at 69 (Feb. 2003), *available at*

http://www.federalreserve.gov/pubs/bulletin/2003/0203lead.pdf. These accounts, even when promptly paid, remain on a credit report as derogatory accounts. Even when some of these accounts are ultimately paid by an insurer, a consumer's credit history may be damaged as result of a lengthy insurance claim adjudication process, confusion due to numerous bills being generated from one visit to a hospital, or even if the insurer is simply slow in paying the bill. *See* Use of Credit Information Beyond Lending: Issues and Reform Proposals: Hearing before the Subcommittee on Financial Institutions and Consumer Credit, House Comm. on Financial Services, 110th Congr. (2010) (statement of Mark Rukavina, Executive Director of The Access Project), *available at* http://www.house.gov/apps/list/hearing/financialsvcs_dem/rukavina_testimony_5.12.10.pdf.

To meet out-of-pocket medical expenses, many consumers are turning to credit cards and, thus, accruing additional medical debt. Overall, 29% of low and middle-income households with credit card debt reported that medical expenses contributed to their current level of credit card debt. Of these, 69% had a major medical expense in the previous three years. Overall, 20% of indebted low- and middle-income households reported both having a major medical expense in the previous three years and that medical expenses contributed to their current level of credit card debt. Cindy Zeldin and Mark Rukavina, Demos, The Access Project,

Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses, 1-3, *available at* http://www.house.gov/apps/list/hearing/financialsvcs_dem/rukavina_testimony_5.12.10.pdf. Among those households who refinanced their homes or took out a second mortgage, 60% of the medically indebted paid down credit cards with the money they received from the refinancing, compared to 48% of the non-medically indebted. *Id*.

With the rise in defaults and hospital bad debt, health care providers are becoming more aggressive in their contemporaneous billing and collection of payments by encouraging consumers to use third-party lenders such as credit cards to pay for medical expenses they cannot afford. In 2001, consumers charged $19.5 billion in health care services to Visa cards. *Id.* "Since out-of-pocket health expenditures have trended upward since 2001 and overall credit card use is on the rise, this figure is probably higher today. Because credit cards are frequently used to pay for medical expenses, it is likely that many estimates and analyses of medical debt actually underestimate the problem." *Id.* Low-to-middle income, medically indebted households surveyed showed many signs of financial stress. Bill collectors have called 62% of medically indebted households, compared to 38% of non-medically indebted households. *Id.*

These undisputed facts in the record demonstrate that the Commonwealth of

Virginia and its citizens suffer from the same problems identified by Congress when it passed the ACA.

SUMMARY OF ARGUMENT

Virginia Organizing demonstrates that the District Court incorrectly concluded that an individual's decision to forego health insurance is not economic "activity" subject to Congressional regulation under the Commerce Clause.

Virginia Organizing's brief below contained numerous facts describing how Virginians participate in the interstate health care market. The Commonwealth of Virginia did not dispute any of those facts. *Amicus* also demonstrated that when Virginians receive health care without paying for it they engage in interstate commerce through additional interstate markets: the secondary markets which include consumer credit and debt financing.

The District Court's definition of the question of economic activity as the "person's decision to refuse to purchase health care insurance" is unduly narrow and conflicts with well established U.S. Supreme Court decisions. *Virginia ex. rel. Cuccinelli v. Sebelius*, 768 F. Supp. 2d 768, 775 (E.D. Va. 2010). The District Court's conclusion that an individual who chooses not to buy insurance is "inactive" or "passive" also reflects an approach that does not correspond to reality. The reality is that people choose how to provide for their health care costs in a number of ways, and waiting to pay for those costs until after they are incurred

is but one of the choices about how to pay for them. Regardless of how that choice is made, a significant effect on the interstate health care market occurs.

ARGUMENT

I. CONGRESS RATIONALLY CONCLUDED THAT CONSUMING HEALTH SERVICES AND DECIDING HOW TO PAY SUBSTANTIALLY IMPACT INTERSTATE COMMERCE.

The District Court's holding that being uninsured is inactivity defies the reality of the market for health care services in Virginia and across this nation. Virginia Organizing demonstrated the enormous economic impact created by the thousands of Virginians and millions in other states who are uninsured. The impact reaches not only Virginia's health care market, with approximately $1.4 billion in unpaid medical costs, but it also pervades the markets for consumer credit and financing, and ultimately increases consumer debt and bankruptcies.

The District Court's narrowing of the question of economic activity to a "person's decision to refuse to purchase health care insurance", *Virginia ex rel. Cuccinelli v. Sebelius,* 728 F. Supp. 2d at 781, also ignores the reality of health care consumer behavior. Being uninsured is not "inactivity" at all because people still need health care services and will attempt to get it. For example, as set forth in his Affidavit submitted to the Court below, Marcus Grimes had only limited insurance coverage which excluded vision treatment when he needed retina

surgery. He asked for a payment plan but that required at least a $3,000 down payment which he could not afford. He launched an unsuccessful campaign to raise money to save his eyesight.

Those who truly cannot afford insurance and who do not qualify for publicly funded insurance obtain health care services nevertheless. They pursue treatment in emergency rooms, hospitals or lower cost clinics and incur enormous debts. They pay out-of-pocket medical costs to the limited extent possible and hope to avoid accidents, illness and catastrophic costs. As the Congress found, the costs of the uncompensated services are passed on to insurers and ultimately to families as higher premium costs. 42 U.S.C.A. § 18091(a) (2) (F).

Year end reports in 2010 about Virginia's health care financing emphasize the consequences of rising health care costs. A November 2010 report from the Commonwealth Institute for Fiscal Analysis explains that Virginia employers cannot afford the higher costs of rising premiums. "The struggles of small employers can be traced to the rising cost of health care coverage. The average yearly health insurance premiums for firms with fewer than 50 employees increased to $4,652 in 2009, which is an almost $400 a year increase in just two years." *Aftershocks: The State of Working Virginia*, Nov. 2010, p. 6, http://thecommonwealthinstitute.org/Portals/16/Labor%20and%20Wage/stateofworkingva10_web.pdf. A small employer who wished to provide a family plan faced

an average cost of " just under $12,500 a year in 2009 for businesses with fewer than 50 workers." *Id* at p. 26.

In other recent developments, Virginia Governor Robert McDonnell appointed an esteemed group of citizens to the Virginia Health Reform Initiative Advisory Council to "develop recommendations about implementing health reform in Virginia, and to seek innovative solutions that meet the needs of Virginia's citizens and its government in 2011 and beyond." *Report of the Virginia Health Reform Initiative Advisory Council*, December 20, 2010, p. i, http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010.pdf. The Committee determined that over the last ten years, "premium growth has exceeded health care costs growth consistently, and that premium growth is outstripping economic growth in general." *Id.* at 3-4. Workers confront compound problems of declining income relative to higher out of pocket costs for premiums and increased cost-sharing at the point of service. *Id.*

The District Court also incorrectly concluded that the Minimum Coverage Provision is an attempt to regulate inactivity. This construction inaccurately simplifies the effects and operation of the multiple parts of the ACA. As the Secretary has argued, the decision of a consumer not to purchase health insurance is not the determinant of economic activity. Rather, the determinants are decisions

about the timing and manner of payment for health care in the aggregate which impact the interstate health care market. Doc 20, pp. 45-46.

The Commonwealth articulated a position which presumed that the interstate commerce determination is measured by a consumer's conduct at a static moment in time. *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp at 779. Well established Commerce Clause case law shows there is no jurisprudential basis for such a cramped interpretation. *Gonzalez v. Raich,* 545 U.S. 1, 19 (2005). "[E]conomic activity must be understood in broad terms . . . a cramped view of commerce would cripple a foremost federal power and in so doing would eviscerate national authority." *Gibbs v. Babbitt*, 214 F.3d 483, 491 (4th. Cir. 2000), *cert denied sub nom, Gibbs v. Norton,* 531 U.S. 1145 (2001).

Contrary to the Commonwealth's academic application, in the real world in which the ACA does and will operate, few of Virginia's uninsured citizens live without health insurance because of a philosophical choice or a measured cost-benefit analysis. The ACA's application should be examined in the real world rather than in an academic hypothetical. In reality, most uninsured Virginians remain uninsured for a simple reason – they cannot afford otherwise. The ACA was enacted in significant part to accomplish structural changes in the health insurance system sufficient to make affordable coverage available to these consumers.

A consumer's decision not to purchase health insurance is not only a timing decision about when to spend money on health care, but is also an active choice as to means of payment. This is not "inactivity." A cramped reading of Commerce Clause jurisprudence like the Commonwealth asserted below leads to incorrectly characterizing the facts of the interstate health care market. A consumer does not have two simple choices – purchase health care through insurance or do not purchase health care. Instead, the consumer faces a multitude of alternative activities; only in an exceptional instance can one hypothesize literally zero use of the health care system.

When a consumer needs medical treatment for emergency conditions, he or she will often choose an emergency room of one of Virginia's larger hospitals. The consumer knows the hospital must provide treatment for serious conditions and relies on that fact. Making this decision and acting on this information are economic activity.

In fact, seeking services at many of Virginia's large hospitals is itself interstate commerce. Several of the hospitals discussed above, *infra* at 6, are parts of multi-state health systems. Henrico Doctors Hospital, John Randolph Medical Center, and CJW Medical Center in the Richmond area are part of the Hospital Corporation of America (HCA) Virginia Health System which operates 13 acute care hospitals and 13 outpatient centers. HCA Virginia's annual payroll exceeds

$666 million. HCA Virginia's parent corporation, HCA Inc., is headquartered in Nashville, Tennessee, and is the nation's leading provider of healthcare services with 157 hospitals plus 105 surgery centers across 20 states and in London, England. *About the HCA Virginia Health System,* http://www.hcavirginia.com/CustomPage.asp?guidCustomContentID={B0963968-65B4-4130-BC25-5C0D8A1BE3DA} (last visited Mar. 6, 2011). The two Bon Secours hospitals in Richmond are affiliated with a multi-state not-for-profit Catholic health system headquartered in Maryland. A $2.9 billion health care provider, Bon Secours Health System owns, manages, or joint ventures eighteen acute-care hospitals plus additional nursing, assisted living and home care programs. Bon Secours health facilities operate in seven states, primarily on the East Coast. *Bon Secours Health Systems,* http://bshi.com/.

Consumers who cannot afford full health insurance engage in a wide range of other alternate activities. For example, in a March 2010 survey conducted by Kaiser, 39% of consumers relied on home remedies or over the counter drugs instead of going to see a doctor because they could not afford the cost. Kaiser Family Foundation *Kaiser Health Tracking Poll* Mar. 9, 2010, http://www.kff.org/kaiserpolls/8058.cfm. This substitution of a homegrown commodity such as home remedies or self-prescribed over the counter medication for an acknowledged interstate commerce commodity, health care insurance, is a

fact pattern fully analogous to that in *Wickard v. Filburn*, 317 U.S. 111(1942). As Professor Jack Balkin explained:

> From an economic standpoint, the failure to purchase health insurance is a method of self-insurance. …. [U]ninsured persons substitute the purchase and use of emergency medical services and over-the-counter health remedies, which is clearly economic activity under *Raich* and cumulatively affects interstate commerce. (Moreover, these services and remedies use or consist of goods and services that travel interstate.) Congress can surely regulate persons who use and purchase emergency services and over-the-counter health remedies because of their cumulative effects on interstate commerce; therefore, if it chooses, it may also require them to purchase health insurance, especially as part of a comprehensive regulatory scheme.

Jack M. Balkin[2], *The Constitutionality of an Individual Mandate for Health Insurance*, 158 U. Pa. L. Rev. 102, 108 (2009).

Courts must defer to a "congressional finding that a regulated activity affects interstate commerce, if there is any rational basis for such a finding." *Hodel v. Virginia Surface Mining & Reclamation Assoc.,* 452 U. S. 264, 276 (1981); *Heart of Atlanta Motel v. United States,* 379 U.S. 241, 258 (1964). In enacting the ACA, Congress appropriately concluded that the economic activity of health care consumers in the aggregate impacts the interstate health care market.

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[2] Knight Professor of Constitutional Law and the First Amendment, Yale Law School.

II. IN THE ACA, CONGRESS RATIONALLY CHOSE A SYSTEM TO REGULATE THE ESTABLISHED SECONDARY MARKET EFFECTS CAUSED BY THE DECISION TO FOREGO HEALTH INSURANCE.

In addition to its findings on cost containment and quality health care, Congress also relied in the ACA upon the large and national economic effects faced by the uninsured:

> 62 % of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

42 U.S.C.A. § 18091 (a)(2)(G). Congress' conclusions about the expected effects on the "financial security of families" are fully supported by the available facts. The objective of the ACA is significant and represents an alternate basis to accept Congress' conclusions about the substantial effects on interstate commerce. Consumers' large medical debts become a part of the secondary markets controlling consumer credit and debt financing.

Congressional power to intercede in interstate commerce on this basis cannot be credibly disputed. The Commerce Clause was long ago recognized as authorizing Congress' enactment of the Consumer Credit Protection Act, 15 U.S.C. § 1601, et seq., *Perez v. United States*, 402 U.S. 146, (1971). Similarly the statutory protections for consumers in the **Truth in Lending Act** are "within the

power granted to Congress under the **Commerce Clause**." *Mourning v. Family Publications Service,* 411 U.S. 356, 377 (1973).

Nearly every aspect of the consumer's accrual of medical debt is within the class of activities as established Commerce Clause powers. Overall, 29% of low and middle-income households with credit card debt reported that medical expenses contributed to their current level of credit card debt, and 20% reported both having a major medical expense in the previous three years and that medical expenses contributed to their current level of credit card debt. *Infra* at 10

Medical debts which consumers do not pay by credit card often end up subject to professional debt collectors. As stated above, over 41% of adults reported that they had medical debt or trouble paying medical bills; 62% have been called by debt collectors. Thereafter, the default or delayed payment of medical bills constitutes over half of all credit reporting made by the debt collection industry. *Infra* at 8-10

Given the national and pervasive impact of medical debt on the consumer credit and debt financing interstate markets, Congress' enactment of the ACA was well within its constitutional powers under the Commerce Clause.

CONCLUSION

Secretary Sebelius has demonstrated that enactment of the Affordable Care Act was within the powers granted to Congress under the Commerce Clause. *Amicus* further demonstrates how Virginians, like the citizens of other states, participate in the interstate market for health care services by how they choose to cover medical costs. For the reasons above, the decision of the District Court should be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(d) and 32(a)(7)(B) and Fed. Cir. Rule 32(b). The brief contains 4,059 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6). The brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

Dated: March 7, 2011

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Thomas D. Domonoske, hereby certify that on March 7, 2011, I filed and served the foregoing Brief of Amicus Curiae Virginia Organizing in Support of Appellant with the Clerk of the Court by causing a copy to be electronically filed and served via the appellate CM/ECF system. I also hereby certify that I have caused eight (8) copies to be delivered to the Court by hand delivery, and have caused copies to be served upon the following counsel by first-class mail:

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