Commonwealth of Virginia, Ex Rel. Kenneth T. Cuccinelli, II v. Sebelius Doc. 133 Att. 1

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Richmond Division

COMMONWEALTH OF VIRGINIA
EX REL. KENNETH T. CUCCINELLI II,
in his official capacity as Attorney General
of Virginia,

Plaintiff,

v. Civil Action No. 3:10-cv-00188-HEH

KATHLEEN SEBELIUS,
SECRETARY OF THE DEPARTMENT
OF HEALTH AND HUMAN SERVICES,
in her official capacity,

Defendant.

BRIEF OF AMICUS CURIAE VIRGINIA ORGANIZING IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

*Amicus Curiae V*irginia Organizing files this brief in support of the Motion for Summary Judgment filed by the Defendant, Secretary Kathleen Sebelius ("Secretary"), (ECF No. 90), and in opposition to the Motion for Summary Judgment by the Defendant, Commonwealth of Virginia ("Commonwealth").

I. INTERESTS OF *AMICUS*

Virginia Organizing is a statewide organization with over 8,000 members established to empower Virginians who have traditionally had little or no institutional voice to work democratically for change. Virginia Organizing has identified access to health care as one of the

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major issues 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 doors across the state, gathering information about problems facing health care consumers in Virginia. Over 70% of the Virginians surveyed were in favor of 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, Pub. L. No. 111-148, 124 Stat. 119 (2010), ("ACA") *amended by* the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Its members are already benefiting from the ACA: young adults have returned to their parents' health insurance policies, adults are accessing the high-risk pool, and pre-existing condition limits for children have been eliminated. Virginia Organizing members have an interest in keeping those benefits and in accessing the additional reforms and improvements contained in the ACA legislation.

Virginia Organizing is represented in example herein by one of its members, Marcus Grimes. See Exhibit 1, Declaration of Marcus Grimes

II. STATEMENT OF SUPPLEMENTAL FACTS

The health care crisis and growing difficulties faced by the uninsured in the U.S. economy have been well-documented in this litigation.

Structural Failures in the Virginia Health Insurance Market

1. Virginia has not been spared from this growing crisis. Virginia is one of the 10 wealthiest states in the country. *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.

Despite its relative wealth, the Commonwealth fails to provide adequate support for those who cannot access or afford health coverage, ranking 29th nationwide in the percentage of insured population from 2007-2008, barely besting West Virginia, Tennessee and Kentucky. Kaiser Family Foundation, *State Health Facts*, http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3.

2. Approximately one million Virginians have been uninsured during each of the past three years. Cook Allison, Kenney Genevieve and Emily Lawton, *Profile of Virginia's Uninsured*, ("*Profile*"), The Urban Institute, 2, January 2010. Available at http://www.vhcf.org/uninsured/documents/ProfileofUninsuredinVA_1_29_final_000.pdf.

3. Virginia's infant mortality rate is 7% higher than the U.S. at large. Kaiser Family Foundation, *State Health Facts*, http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3. Nearly 1 in 10 of Virginia's children are uninsured. *Id*. Not surprisingly, most of Virginia's uninsured (60%) are low income people with income below 200% of the federal poverty line ($36,620/year for a family of 3 in 2010). *Profile*, *supra, at* 2.

4. While many Virginians are fortunate to obtain health insurance from their employers, 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. Moreover, the percentage of Virginians under age 65 who get health insurance at work has declined over the last decade, dropping from 71.6% in1999 to 65.7% in 2009. http://www.census.gov/hhes/www/hlthins/data/historical/index.html, Table HIA-6.

5. The consequences of uninsurance as well as 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 cost. Kaiser Family Foundation, *State Health Facts*, http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3. See also, attached affidavit of Marcus Grimes, who lost his vision and ability to work as a teacher as a direct result of his lack of money or health insurance to obtain necessary surgery.

6. Such problems are widespread. In a recent national poll, 57% of respondents indicated that during the last 12 months they had put off their own or their family's medical care because of cost. Approximately 28% skipped a medical test or treatment (compared to 15% in January 2000); 26% could not fill a prescription for medicine (13% in January 2000); 21% cut their pills in half; and 39% "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* (March 10-15, 2010) available at http://www.kff.org/kaiserpolls/8058.cfm.

Uninsured and Uncompensated Medical Care Impacts Virginia's Hospital System.

7. The impoverished and low-income uninsured have few choices: They can forego necessary health care or seek health care from overburdened health clinics or emergency rooms. These gaps in coverage contribute to the 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 burden was confirmed in Virginia Health Information's 2009 Industry Report: Virginia Hospitals and Nursing Facilities, reporting that Virginia hospitals provide more than $1.4 billion dollars annually in uncompensated care to patients—nearly 4% of gross patient revenue. http://www.vhi.org/industry_reports.asp

8. In fact, three Virginia hospitals or 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; 27.3% at Carilion). Presentation of Sheldon M. Retchin, CEO, VCU Health System to Virginia Senate Finance Subcommittee on Health and Human Resources, August 24, 2010. http://sfc.state.va.us/pdf/health/2010%20Session/August24%20Jt%20Mtg/No5VU.pdf, slide 11

9. Virginia hospitals admitted 81,000 uninsured patients in 2008 and incurred $419 million in bad debt expenses (based on cost, not charges). 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:

- 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.

10. The average collection recovery rate for medical billing to uninsured consumers is 17% for hospitals and 21% for other providers. ACA International's Top Collection Markets Survey, Jan. 1 – Dec. 31, 2008 as summarized at http://www.acainternational.org/publications-health-care-information-5434.aspx.

11. The national average for bad debt is 3.03 percent, 2.17 percent for charity and 5.2 percent for total uncollectibles. The Southeast region of the U.S. had the highest percentage of total uncollectibles at 12.8 percent. *The Hospital Accounts Report Analysis (HARA) on Second Quarter 2008* as summarized at http://www.acainternational.org/publications-health-care-information-5434.aspx.

Medical Debt Threatens Credit Availability and Financial Stability.

12. Medical debt is a growing problem with 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 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.accessproject.org/adobe/borrowing_to_stay_healthy.pdf. Lapses in health insurance are strong predictors of medical debt. *Id.*

13. In 2007, 41 percent of adults reported that they had medical debt or trouble paying medical bills, up from 34 percent in 2005. Press release*, Second National Scorecard on U.S. Health Care System Finds No Overall Improvement; Steep Decline in Access, Scores on Efficiency Especially Low*, The Commonwealth Fund, 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%20Decline%20in/Scorecard08releaseFINAL_7%2014%2008%2002%20pdf.pdf.

14. One study estimates that 62.1% 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 people whose health insurance still does not cover necessary care due to 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. www.BCSalliance.com. In 2009 there were 35,338 non-business bankruptcy filings in Virginia. American Bankruptcy Institute, www.abiworld.org.

15. 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).

16. Many medical bills are referred to collection agencies during these disputes but are ultimately paid by insurers or the patients. These accounts, even when promptly paid off, remain on a credit report as derogatory accounts. 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 Committee 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.

17. To meet out-of-pocket medical expenses, many consumers are turning to credit cards and accruing 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.accessproject.org/adobe/borrowing_to_stay_healthy.pdf.

18. Among those households that 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, as compared to 48% of the non-medically indebted. *Id*.

19. With the rise in defaults and hospital bad debt, health care providers are becoming more aggressive in their contemporaneous collection of billing and 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.*

20. Low-to-middle income, medically indebted households surveyed showed many signs of financial stress. Bill collectors have called 62% of medically indebted households, as compared to 38% of non-medically indebted households. *Id.*

The ACA Benefits Virginians

21. ACA addresses all of the above described problems: The high number of uninsured; unaffordable medical costs and insurance premiums; hospital uncompensated care and bad debt; and the interplay between medical debt, bankruptcy and consumer credit. Beyond the overall impact on interstate commerce, there is a significant impact on individual Virginians.

22. The law will protect approximately 1.5 million Virginians under the age of 65 who have a diagnosed pre-existing condition that would presently lead to a denial of coverage in the individual health insurance market. *One in Five Non-Elderly Virginians Has a Diagnosed Pre-Existing Condition*, Families U.S.A., May 2010, available at http://www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions/virginia.pdf

23. An estimated 41.9% of all uninsured in Virginia are between the ages of 19 and 34. *Profiles* at p. 11. The ACA will allow 1.2 million Virginians under age 30 to have access to less costly catastrophic-only health insurance plans, when health insurance exchanges begin in 2014. Over 28,000 individuals under 26 will be able to stay on their parents' insurance. U.S. Census Bureau, *Current Population Survey*. Annual Social and Economic Supplements, March 2009; http://www.hhs.gov/ociio/regulations/pra_omnibus_final.pdf

24. For the one million Virginians enrolled in Medicare, there will be no cost sharing for preventive care services, and costs will be lower for those with extremely high prescription costs.

25. There are 108,736 employers in Virginia that are potentially eligible for ACA tax credits. http://www.irs.gov/pub/newsroom/count_per_state_for_special_post_card_notice.pdf. Of these, 99,565 – over 91% – are small businesses. Together, these businesses employ about 393,500 Virginians. Agency for Health Care Research and Quality, *Medical Expenditure Panel Survey*, http://www.meps.ahrq.gov/mepsweb/. These tax credits will reduce the cost of health insurance for small businesses, enabling the creation of new jobs. *A Helping Hand for Small Businesses: Health Insurance Tax Credits,* Table 1 (July 2010), available at http://www.smallbusinessmajority.org/_pdf/tax_credit/Helping_Small_Businesses.pdf.

III. ARGUMENT

The Patient Protection and Affordable Care Act will significantly improve access to healthcare in the Commonwealth of Virginia, where over one million individuals are uninsured. The ACA's "Minimum Essential Coverage" provision, § 1501, the subject of this litigation, is a critical part of the overall legislation. It is the essential element that ensures near-universal coverage and allows for significant reforms to private insurance. Those reforms, such as eliminating caps on coverage and pre-existing condition restrictions, reflect fundamental and necessary changes to the healthcare industry in the United States.

Relying on incentivized structural improvements in the private health insurance market, the ACA offers past, present and future healthcare consumers – including essentially all Virginians – an opportunity for real market-based reforms in the way that healthcare will be paid for and insured.

A. THE COMMONWEALTH'S UNDERSTANDING OF LAW IS OUTSIDE MAINSTREAM JURISPURUDENCE.

The legal question centrally framed by the Court in its Memorandum Opinion denying the Secretary's Motion to Dismiss was "whether or not Congress has the power to regulate – and tax – a citizen's decision not to participate in interstate commerce." Memorandum Opinion Denying Defendant's Motion to Dismiss at 31 (August 2, 2010) ECF No. 84. This argument construction asserted by the Commonwealth is in error, as is its characterization of Congress' belief in the constitutionality of the ACA as somehow groundbreaking, unresolved or remarkable. Outside the vacuum of the case, however, there is significant acceptance that Congress' interpretation of the law is solidly within the bounds of mainstream constitutional jurisprudence. For example, Dean Erwin Chemerinsky, a respected constitutional scholar concluded:

> Those opposing health care reform are increasingly relying on an argument that has no legal merit: that the health care reform legislation would be unconstitutional. There is, of course, much to debate about how to best reform

America's health care system. But there is no doubt that bills passed by House and Senate committees are constitutional.

Erwin Chemerinsky[1], *Health Care Reform Is Constitutional*, Politico, October 23, 2009, http://www.politico.com/news/stories/1009/28620.html. Additional scholars suggest that the creation of the novel Commerce Clause challenges was based more on political and philosophical opposition to the Act than on sound Supreme Court jurisprudence:

> Opponents' arguments to the contrary express philosophical objections to the concept of mandatory health insurance in principle, without regard to the practical issues the Supreme Court has always used to evaluate laws challenged as outside Congress' interstate commerce authority. … Opponents' real grievance is with the law in its current state. Their hope is that a majority of the Supreme Court will seize on a challenge to mandatory health insurance as an occasion to make major changes in current law. But their arguments appear unlikely to gain traction with the current Supreme Court, and, indeed, represent approaches and theories that have been repudiated by justices across the Court's ideological spectrum.

Simon Lazarus[2], *Mandatory Health Insurance: Is It Constitutional?*, American Constitution Society Issue Brief, December 2009, at 1, http://www.acslaw.org/pdf/Lazarus%20Issue%20Brief%20Final.pdf. Even for its proponents, the Commonwealth's argument is an acknowledged long shot. *See* Randy E. Barnett, *Is Health-Care Reform Constitutional?*, Wash. Post, March 21, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/19/AR2010031901470.html ("[T]he smart money says there won't be five (Supreme Court) votes to thwart the popular will to enact comprehensive health insurance reform.")

While Plaintiff asserts, "Although the Commonwealth's position is in accord with existing precedent, acceptance of the Secretary's position would require a change in the existing law,"

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[1] Dean and distinguished professor of law at the University of California, Irvine School of Law.

[2] Public Policy Counsel to the National Senior Citizens Law Center. Mr. Lazarus also credits Professor Timothy Stoltzfus Jost, Robert L. Willett Professor at the Washington and Lee University School of Law.

Plaintiff's Memorandum in Support of Motion for Summary Judgment at 5 (September 3, 2010) ECF No. 89, in truth, the creative and novel opposition to the ACA pursued by the Commonwealth and its allied Amici is premised not on what the law presently is, but instead on what they wish it to become. As Mr. Lazurus explained:

> Opponents' real grievance is with the state of the law itself, what CATO Institute legal expert Michael Cannon characterizes as "the Supreme Court's tortured interpretation of the Commerce Clause," which, he and CATO Board Chair Robert A. Levy grimly acknowledge, permits "[e]ven noncommercial activities within a state [to] be restricted if they threaten to undercut federal regulation of interstate markets."

Simon Lazarus, *Mandatory Health Insurance: Is It Constitutional?*, at 9-10.

B. CONGRESS' ENACTMENT OF THE ACA AND IMPOSITION OF THE MINIMUM ESSENTIAL COVERAGE REQUIREMENT WERE RATIONALLY BASED ON ITS CONCLUSION THAT THE DECISION OF HOW AND WHEN TO PAY FOR HEALTH CARE SUBSTANITALLY IMPACTS INTERSTATE COMMERCE.

The Commonwealth incorrectly characterizes the Minimum Coverage Provision as an attempt to regulate inactivity. This construction of the case issue grossly simplifies the effects and governance of the ACA. As the Secretary has argued, the decision of a consumer not to purchase health insurance is not the decision to remain economically inactive. Rather, it is a decision solely as to timing and manner of payment for health care that will in all certainty be transacted. The Commonwealth ignores this point and instead asks the Court to presume that the interstate commerce determination is measured by a consumer's conduct at a static moment in time. That is, if a consumer is compelled by the ACA to purchase insurance on October 4, the Commonwealth's position is dependent upon the legal assumption that the activity in commerce would also need to occur on October 4. There is certainly no jurisprudential basis for such measure, nor any logic to it.

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. It is likely that all or nearly all of the defenders in this case of the "right to remain uninsured" (those most inclined to such a philosophical exercise) are themselves fully insured (evidencing the outcome of any reasoned affordable choice.) The ACA's application should be examined in the real world rather than in by academic hypothetical. In reality, Virginians remain uninsured for a simple reason – they cannot afford otherwise. As offered *supra*, 60% of Virginia's uninsured are low income. The vast remainder are middle class. 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.

Not only is a consumer's decision not to purchase health insurance a timing decision as to when to spend money on health care, but it is also an active choice as to means. This is not "inactivity." *Wickard v. Filburn*, 317 U.S. 111 (1942). In *Wickard*, Congress sought to restrict homegrown wheat in lieu of regulated wheat. The Commonwealth argues that the case is inapposite to the ACA's individual mandate as it involved the substitution of one commodity for another – of one activity for another. Such an explanation, even if an accurate shorthand of *Wickard*, is an inaccurate statement of fact as to the present case. There are not simply two choices for a consumer – purchase health care through insurance or do not purchase health care. Instead, there are a multitude of alternative activities such that only in an exceptional instance can one hypothesize literally zero use of the health care system. Consumers who cannot then afford full health insurance engage in a wide range of 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* (March 10-15, 2010) available at http://www.kff.org/kaiserpolls/8058.cfm. This substitution of a homegrown commodity (home remedies or self-prescribed over the counter medication) for an acknowledged interstate commerce commodity (health care purchased through insurance) is a fact pattern fully analogous to that in *Wickard*. As Professor 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[3], The Constitutionality of an Individual Mandate for Health Insurance, 158 U. Pa. L. Rev. 102, 108 (2009).

C. IN ENACTING THE ACA, CONGRESS SOUGHT TO PROTECT CONSUMERS FROM BANKRUPTCY AND CREDIT INSECURITY.

In addition to its findings as regards cost containment and quality health care, Congress also founded its passage of the ACA upon the large and national in scope economic effects otherwise faced by the uninsured:

> (E) Half 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.

H.R. 3590, 111th Cong. § 1501(a)(2)(E) (2009). Congress' conclusions as regards the expected effects on the "financial security of families" are as well more than supported by the facts

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

available. This objective of the ACA is significant and represents an alternate basis to accept Congress' substantial effect conclusion.

Congress' power to intercede in interstate commerce on this basis cannot thus 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). Nearly every aspect of the consumer's accrual of medical debt is within the class of activities within established Commerce Clause powers. First, 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 7.

Those debts that are not paid by credit card often then end up subject to professional debt collectors. As stated in Amicus's statement of supplemental facts 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 7.

Given the national and pervasive impact of such economic effects, Congress' enactment of the ACA was well within its constitutional powers under the Commerce Clause.

IV. CONCLUSION

For the reasons set forth above, this Court should grant Defendant's Motion for Summary Judgment.

Dated: October 4, 2010

Virginia Organizing, Amicus Curiae

__________/s/______________________
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CERTIFICATE OF SERVICE

I hereby certify that on October 4, 2010, I electronically filed the foregoing by using the CM/ECF system. All participants in the case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

Dated: October 4, 2010

____________/s/_______________

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