Nos. 11-11021 & 11-11067

IN THE

United States Court of Appeals for the Eleventh Circuit

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees / Cross-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants-Appellants / Cross-Appellees.

On Appeal from the United States District Court
for the Northern District of Florida

BRIEF AMICI CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION ET AL. IN SUPPORT OF DEFENDANTS-APPELLANTS / CROSS-APPELLEES

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IN THE

United States Court of Appeals for the Eleventh Circuit

STATE OF FLORIDA, et al.,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.

Nos. 11-11021 & 11-1067

RULE 26.1 CERTIFICATION

Pursuant to Fed. R. App. P. 26.1 and 11th Cir. R. 26.1-1, amici the American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, and National Association of Public Hospitals and Health Systems make the following disclosure: Each amicus is a nonprofit association representing America's hospitals. None has a publicly owned parent corporation, subsidiary, or affiliate, and none has issued shares or debt securities to the public. As a result, no publicly held company owns 10 percent or more of the stock of any of the above-named amici.

Counsel certifies that she believes that the Amended Certificate of Interested Persons and Corporate Disclosure Statement filed by Appellants is complete.

Catherine E. Stetson /DFP, by express permission

Catherine E. Stetson

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STATEMENT OF THE ISSUES PRESENTED

1. Whether the District Court erred in holding that the individual mandate of the Patient Protection and Affordable Care Act ("ACA") is not a valid exercise of Congress's commerce power.

2. Whether the District Court correctly held that the ACA's expansion of the Medicaid program is consistent with Congress's powers under the Spending Clause.

STATEMENT OF INTEREST OF AMICI CURIAE

The American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, and National Association of Public Hospitals and Health Systems (the "Hospital Associations") respectfully submit this brief as amici curiae.[1]

The American Hospital Association ("AHA") represents nearly 5,000 hospitals, health care systems, and networks, plus 37,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

The Association of American Medical Colleges ("AAMC") represents about 300 major non-federal teaching hospitals, all 134 allopathic medical schools, and the clinical faculty and medical residents who provide care to patients there.

The Catholic Health Association of the United States ("CHA") is the national leadership organization for the Catholic health ministry. CHA's more

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[1] Pursuant to Federal Rule of Appellate Procedure 29, amici certify that all parties have consented to the filing of this brief. Amici likewise certify that no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund the brief's preparation or submission; and no person other than amici and their members and counsel contributed money

than 2,000 members operate in all 50 states and offer a full continuum of care, from primary care to assisted living. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and the District of Columbia. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services.

The National Association of Children's Hospitals ("N.A.C.H.") is a trade organization that supports its 141 hospital members in addressing public policy issues. N.A.C.H.'s mission is to promote the health and well-being of children and their families through support of children's hospitals and health systems.

The National Association of Public Hospitals and Health Systems ("NAPH") is comprised of some 140 of the nation's largest metropolitan safety net hospitals and health systems, committed to providing health care to all without regard to ability to pay. NAPH represents members' interests in matters before Congress, the Executive Branch, and the courts.

The six Hospital Associations represent virtually every hospital and health system in the country—public and private; urban and rural; teaching and children's

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intended to fund the brief's preparation or submission.

hospitals; investor-owned and non-profit. Their members will be deeply affected by the outcome of this case. American hospitals are committed to the well-being of their communities and offer substantial community-benefit services. As part of that mission, they dedicate massive resources to caring for the uninsured. The uninsured, after all, need health care like everyone else. Nearly every hospital with an emergency department is required to provide emergency services to anyone, regardless of ability to pay. And even when an uninsured patient arrives planning to pay his or her own way, that patient may struggle to pay for an extended stay. The upshot: Hospitals treat tens of millions of uninsured individuals each year, and most of that care is uncompensated. Indeed, in 2009 alone, hospitals provided more than $39 billion in uncompensated care to the uninsured and under-insured. American Hosp. Ass'n, Uncompensated Hospital Care Cost Fact Sheet 4 (Dec. 2010) ("Fact Sheet");[2] see also J. Hadley et al., Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs 403, Health Affairs (Aug. 25, 2008) ("Covering The Uninsured").[3] And while hospitals do all they can to assist patients, burdens on uninsured individuals remain heavy. Millions of families are just one major illness from financial ruin.

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[2] Available at http://www.aha.org/aha/content/2010/pdf/10uncompensatedcare.pdf.

[3] Available at http://content.healthaffairs.org/cgi/reprint/27/5/w399.

That is why the Hospital Associations favored enactment of the ACA. While the legislation is not perfect, it would extend coverage to millions more Americans. To undo the ACA now would be to maintain an unacceptable status quo—a result that is neither prudent nor compelled by the Constitution.

SUMMARY OF ARGUMENT

1. The District Court's ruling on the ACA's individual mandate was error for at least three separate reasons.

First, contrary to the District Court's conclusion, "activity" is not an independent requirement of congressional regulation under the Commerce Clause.

Second, even if "activity" were an independent requirement for Commerce Clause regulation, such activity plainly exists here. The vast majority of uninsured individuals are quite actively engaged in interstate commerce; they seek and receive tens of billions of dollars a year worth of health care services. Third parties—including hospitals, doctors, clinics, health care systems, and other patients—end up absorbing the majority of those costs. The individual mandate does not compel uninsured individuals to participate in interstate commerce; it merely directs them to arrange payment for the services they already are seeking and receiving in interstate commerce.

Third, even if "activity" were required and even if it were absent here, that would be irrelevant. Congress had authority to enact the individual mandate as an essential element of the ACA's larger regulatory scheme.

2. The District Court correctly rejected Appellees' challenge to the ACA's expansion of Medicaid, finding it contrary to well-established case law. The ACA's Medicaid provisions are not impermissibly coercive. And Appellees would set a dangerous precedent by effectively forcing Congress to obtain consent from each participating state before modifying the Medicaid program to address the shifting needs of patients and health care providers.

ARGUMENT

I. THE CLAIM THAT UNINSURED INDIVIDUALS ARE "INACTIVE" IS LEGALLY IRRELEVANT.

The individual-mandate argument embraced by the District Court is premised on the notion that, by requiring many Americans to obtain health insurance, Congress is regulating inactivity. Florida v. U.S. Dep't of Health & Human Services, No. 3:10-cv-91-RV/EMT, 2011 WL 285683, at *29 (N.D. Fla. Jan. 31, 2011). In particular, the District Court explained "that the individual mandate seeks to regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress's commerce power, as it is understood, defined, and applied in the existing Supreme Court case law." Id. These

conclusions fail for at least three separate reasons. Amici address the first two only briefly, as they are more fully set forth by the Government. See Brief of the United States 32-49.

First, the District Court erred in finding that "activity" is an independent requirement of congressional regulation under the Commerce Clause. The Supreme Court has never created an "activity" requirement. On the contrary, the Court has used the term only as a descriptor in discussing the broad outlines of Congress's power, see United States v. Lopez, 514 U.S. 549, 567 (1995) (explaining that legal standards for the Commerce Clause "are not precise formulations, and in the nature of things they cannot be"), and has not used it in every instance when describing congressional power. See, e.g., Gonzales v. Raich, 545 U.S. 1, 17 (2005) (Congress may regulate "a practice" that poses "a threat to the national market"). Nor would it make sense to require "activity" as a separate prong of the Commerce Clause analysis. The relevant question under the Commerce Clause is not whether Congress is targeting activity, but whether the object of congressional regulation is causing a substantial "impact on commerce." Maryland v. Wirtz, 392 U.S. 183, 196 n.27 (1968).

Indeed, to superimpose an activity requirement "is to plunge the law in endless difficulties," Steward Mach. Co. v. Davis, 301 U.S. 548, 589-590 (1937), because whether a regulated individual is engaged in relevant activity depends on

one's perspective: As we discuss infra at 20-23, almost any individual subject to regulation can be described as "active" or "inactive," depending on the level of generality one adopts. The law does not turn on these sorts of malleable distinctions. And when such distinctions have been created in the past, they have quickly been abandoned as unworkable failures. See Wickard v. Filburn, 317 U.S. 111, 120 (1942) ("[Q]uestions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' * * * .").

Second, even if "activity" were required to justify a free-standing regulation, and even if it were absent here—which it is not, as we discuss at length below—that would be irrelevant. The individual mandate is not a free-standing regulation; it is, instead, an important component of the ACA's comprehensive regulatory reform of the interstate health care and health insurance markets. See Mead v. Holder, Civ. Action No. 10-950 (GK), 2011 WL 611139, at *17 (D.D.C. Feb. 22, 2011) ("[T]he individual mandate is best viewed not as a stand-alone reform, but as an essential element of the larger regulatory scheme contained in the ACA."). As such, Congress has the authority to enact it. As the Supreme Court explained in Raich, Congress is well within its Commerce Clause authority when it regulates individuals—even individuals not participating in interstate commerce—as an integral part of "a lengthy and detailed statute creating a comprehensive

framework" governing a larger interstate market. 545 U.S. at 24; accord Hodel v. Indiana, 452 U.S. 314, 329 n.17 (1981). The ACA is "a lengthy and detailed statute creating a comprehensive framework" governing an interstate market if ever there was one. Raich, 545 U.S. at 24. Because the individual mandate plays an integral role in facilitating Congress's regulation of that market, it is a valid exercise of Congress's authority under the Commerce Clause and the Necessary and Proper Clause.

II. THE CLAIM THAT UNINSURED INDIVIDUALS ARE "INACTIVE" IS FACTUALLY INCORRECT.

The District Court's analysis fails for both of these reasons . But amici wish to focus in greater detail on a third, independent reason why this Court should reverse: Even if the Commerce Clause limited Congress to the regulation of "activity," the requirement would be met in this case because uninsured Americans unquestionably participate in relevant economic activity—they obtain health care services. Indeed, the uninsured engage in that activity in massive numbers and with great frequency. The vast majority of uninsured individuals receive health care services regularly, and the cost (to the patients themselves, those who treat them, and taxpayers) is extraordinary. Thus an individual's decision to purchase or decline health insurance is nothing other than a decision about whether he will pay, or ask others to pay, for existing and future health care costs—i.e., how he will pay for services he will receive. That is quintessential economic activity.

The District Court concluded that the uninsured are engaged in mere "inactivity" by focusing on the health insurance market and ignoring the broader market Congress chose to regulate through the ACA—the health care market. See 42 U.S.C. § 18091(a)(2)(A). The Court should reject this invitation to redefine the lens through which Congress viewed the facts. Congress was entitled to perceive its task as the regulation of the whole health care market, and to recognize that health insurance serves as a financing mechanism in that broader market.[4] Under rational basis review, the Court must "respect the level of generality at which Congress chose to act." United States v. Nascimento, 491 F.3d 25, 42 (1st Cir. 2007) (citing Raich, 545 U.S. at 22).

A. Because The Uninsured Are Virtually Certain To Accrue Health Care Costs, The Decision To Purchase Or Decline Insurance Is "Economic Activity."

All Americans—insured and uninsured alike—make use of the health care system, thus accruing health care costs. Given this reality, all individuals must

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[4] In any event, the health insurance market and the health care market are inextricably linked. As the District Court for the District of Columbia recently acknowledged, because health care providers pass certain uncompensated health care costs on to private insurers, "the individual decision to forgo health insurance, when considered in the aggregate, leads to substantially higher insurance premiums for those other individuals who do obtain coverage." Mead, 2011 WL 611139, at *16. Higher premiums may, in turn, dissuade some consumers from purchasing health insurance, increasing the size of the uninsured population and thereby ultimately increasing the burden on health care providers. In sum, efforts to regulate payment in the health care market invariably will affect the health insurance market and vice versa.

make a decision as to how to finance these costs. That decision is economic activity, and the individual mandate regulates this marketplace behavior.

1. Simply stated, uninsured Americans are engaged in economic activity because they seek and obtain large amounts of health care, and someone must pay the tab. In 2008 alone, the most recent year for which full statistics are available, the uninsured received $86 billion worth of health care from all providers. Covering The Uninsured 399, 402-403; see infra at 15-18. The uninsured also made more than 20 million visits to hospital emergency rooms. U.S. Dep't of Health & Human Servs., New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits (July 15, 2009).[5] And without the individual mandate, those numbers likely would continue to rise. The number of adults aged 18-64 who go without health insurance for some portion of the year has been increasing steadily over the past few years. Centers for Disease Control and Prevention, Vital Signs: Access to Health Care (Nov. 9, 2010).[6] Approximately 50 million people fell into this category over the course of the past twelve months. Id.

The vast majority of these millions of uninsured individuals—at least 94 percent—seek and receive health care services at some point. J. E. O'Neill and D.M. O'Neill, Who Are the Uninsured? An Analysis of America's Uninsured

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[5] Available at http://www.hhs.gov/news/press/2009pres/07/20090715b.html.

[6] Available at http://www.cdc.gov/vitalsigns/HealthcareAccess/index.html.

Population, Their Characteristics and Their Health 21 & Table 9 (2009) ("Who Are The Uninsured").[7] For example, 68 percent of the uninsured population had a routine check-up in the past five years, and 50 percent had one in the past two years. Id. at 20. Sixty-five percent of uninsured women had a mammogram within the last five years; 80 percent of uninsured women had a Pap smear in that time frame; and 86 percent of uninsured individuals had a blood pressure check. Id. at 20-22 & Table 9. The takeaway is simple enough: "[T]he uninsured receive significant amounts of healthcare[.]" Id. at 24. The uninsured thus are not "inactive" in the health care market; they are frequent participants. And their decision to decline health insurance is an economic decision directly related to the services they routinely receive. It is a decision about how to pay—or ask others to pay—for services rendered.

2. Nor is there any doubt that the overwhelming majority of uninsured individuals do—and must—participate in this market, even absent the individual mandate. Nearly all people, sooner or later, receive health care whether they would have chosen to or not. When a person has a medical crisis, or is in a car accident, or falls and breaks a limb, he or she is transported to the hospital and provided care. Most Americans thus cannot simply "exit" the health care market. The choice they face, instead, is how to pay for the care they inevitably will

[7] Available at http://epionline.org/studies/oneill_06-2009.pdf.

receive. By forgoing insurance, individuals simply shift the burden of their health care payments to others. See infra at 15-18. The health care market is unique in this respect. The combination of actions it requires of consumers—accepting services and deciding how to pay for them—is economic activity, pure and simple, and is subject to congressional regulation under the Commerce Clause.

While the District Court acknowledged that many uninsured individuals seek and obtain health care services, it expressed concern that there always may be some small percentage of uninsured individuals who do not receive health care. It suggested that that fact renders the individual mandate unconstitutional. See Florida, 2011 WL 285683, at *26 (explaining that to avoid "cast[ing] the net" too "wide," Congress should regulate the uninsured only when they actually seek health care services). But the fact that some small percentage of uninsured Americans may not receive care does not change the constitutional calculus. Congress may consider and regulate the market in the aggregate, and the courts will not "excise individual components of that larger scheme." Raich, 545 U.S. at 22; see also Wirtz, 392 U.S. at 192-193.

3. The District Court's "inactivity" finding also obscures an important reality: Although the uninsured population seeks and receives significant amounts of preventive care, the uninsured still receive far less preventive care than the insured. Who Are The Uninsured at 20-22 & Table 9. The decision of some

uninsured individuals to put off regular preventive care actually increases their activity in the health care market in the long run. That is because "[d]elaying or forgoing needed care can lead to serious health problems, making the uninsured more likely to be hospitalized for avoidable conditions." Kaiser Comm'n on Medicaid & the Uninsured, The Uninsured & the Difference Health Care Makes 2 (Sept. 2010).[8] As the Centers for Disease Control and Prevention observed: "Approximately 40 percent of persons in the United States have one or more chronic disease[s], and continuity in the health care they receive is essential to prevent complications, avoidable long-term expenditures, and premature mortality." J. Reichard, CDC: Americans Uninsured at Least Part of the Year on the Rise, Harming Public Health, CQ Healthbeat News (Nov. 9, 2010) (emphasis added). For example, "[s]kipping care for hypertension can lead to stroke and costly rehabilitation" and "[s]kipping it for asthma can lead to hospitalization." Id. This is not mere rhetoric. Studies have shown that "[l]ength of stay" in the hospital is "significantly longer" for uninsured patients who suffer from heart attacks, stroke, and pneumonia than for insured patients with those conditions—a disparity researchers attribute at least in part to "uninsured patients' lack of access to primary care and preventive services." E. Bakhtiari, In-Hospital Mortality Rates

[8] Available at http://www.kff.org/uninsured/upload/1420-12.pdf.

Higher for the Uninsured, HealthLeaders Media (June 14, 2010).[9] For this reason, too, it makes little sense to suggest that people affected by the individual mandate are inactive. Any decision to avoid the health care market in the short term simply produces more market activity in the medium and long term. Congress had the authority to recognize as much, and to regulate the uninsureds' choice about who will pay for that market activity.

B. Care Provided To The Uninsured Costs Billions Per Year, And Everyone In The Nation Helps To Pay The Bill.

Uninsured Americans, in short, regularly obtain health care services and decide how (and whether) to pay for them—"activities" in the market by any measure. And those services are costly. As mentioned above, the uninsured pay a substantial portion of the bill themselves—a whopping $30 billion in 2008 alone. Covering The Uninsured 399. But an even greater share is borne by hospitals, health systems, doctors, insurers, and even other patients. Because the uninsured create an enormous cost for the market, the activity they engage in is "economic," and Congress may regulate it.

1. To begin with the providers: Of the $86 billion in care the uninsured received in 2008, about $56 billion was uncompensated care provided by hospitals,

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[9] Available at http://www.healthleadersmedia.com/content/QUA-252419/InHospital-Mortality-Rates-Higher-for-the-Uninsured.html.

doctors, clinics, and health care systems.[10] That $56 billion exceeds the gross domestic product of some 70 percent of the world's nations. Covering The Uninsured 399, 403; see T. Serafin, Just How Much is $60 Billion?, Forbes Magazine (June 27, 2006).[11] All hospitals and health care providers, large and small, shoulder these uncompensated-care costs. See National Ass'n of Pub. Hosp. & Health Sys., What is a Safety Net Hospital? 1 (2008).[12] But the costs fall particularly heavily on "core safety-net" hospitals—the term for hospitals or health systems that serve a substantial share of uninsured, Medicaid, and other vulnerable patients. Institute of Med., America's Health Care Safety Net: Intact But Endangered (2000).[13] For these hospitals, uncompensated care amounts to some 21 percent of total costs. What is a Safety Net Hospital? 1.

To be sure, hospitals bear many of these expenses as part of their charitable mission—but that does not change the fact that an uninsured individual's decision to seek care is, and triggers, economic activity. A description of how hospitals

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[10] This is derived by subtracting $30 billion in uninsured self-payment from the $86 billion total. See supra at 11, 15. Of the $56 billion in uncompensated care, some $35 billion is provided by hospitals, and the rest by doctors, clinics, and other providers. Covering The Uninsured 402-403.

[11] Available at http://www.forbes.com/2006/06/27/billion-donation-gates-cz_ts_0627buffett.html.

[12] Available at http://literacyworks.org/hls/hls_conf_materials/WhatIsASafetyNetHospital.pdf.

[13] Available at http://www.iom.edu/~/media/Files/Report%20Files/2000/Americas-Health-Care-Safety-Net/Insurance%20Safety%20Net%202000%20%

work to serve uninsured patients illustrates the point. As noted above, nearly every hospital with an emergency department is required to provide emergency services to anyone, regardless of ability to pay. See Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA"), 42 U.S.C. § 1395dd. But even when the patient's need does not rise to the level of an emergency, hospitals provide free or deeply discounted care. Most hospitals' policies "specify that certain patients," such as "those who do not qualify for Medicare or other coverage and with household incomes up to a specified percentage of the Federal Poverty Level or 'FPL,' " will not be charged at all for the care they receive. Healthcare Fin. Mgmt. Ass'n, A Report from the Patient Friendly Billing Project 8 (2005).[14] Other patients, such as those "with incomes up to some higher specified percentage of the FPL," will "qualify for discounts on their hospital bills." Id.

Most uninsured (and under-insured) patients with incomes that exceed these levels, however, also face difficulty paying for services, especially if they require an extended hospital stay. Despite their incomes, some may qualify for reduced-price care under hospital policies that assist the "medically indigent"—i.e., "patients whose incomes may be relatively high, but [whose] hospital bills exceed a certain proportion of their annual household income or assets." Id. at 11. For

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20report%20brief.pdf.

[14] Available at http://www.hfma.org/HFMA-Initiatives/Patient-Friendly-Billing/PFB-2005-Uninsured-Report.

others, hospitals offer financial counseling, flexible payment plans, interest-free loans, and initiatives that help patients apply for grants or Medicaid. Id. at 11-15. These services advance hospitals' missions to serve the community—but they also require substantial time and resources that add to the already massive costs hospitals absorb to treat the uninsured.

2. In the final analysis, hospitals and other health care providers provide tens of billions of dollars worth of uncompensated care per year, including services to the uninsured and under-insured. Fact Sheet 4. They do not shoulder the burden alone, however. Supplemental Medicare and Medicaid payment programs also fund care for the uninsured—in other words, American taxpayers share the cost. Covering The Uninsured 403-404. State and local governments—taxpayers again—likewise fund certain of these expenses. Id. at 405. Finally, insured patients (and their insurers) end up effectively paying some portion of the bills generated by their uninsured counterparts: As hospitals and other providers absorb costs of uncompensated care, they have fewer funds to reinvest and to cover their ongoing expenses, and that in turn drives costs higher. Id. at 406. In short, the vast cost of health care for the uninsured is, of necessity, borne by the rest of the nation, and it affects prices in the health care and the health insurance markets. To say the uninsured render themselves "inactive" by declining to purchase insurance is to ignore reality. The uninsured still obtain health care; others just pay for it.

C. Attempts To Analogize This Case To Lopez Fail.

Appellees argued below that attempts to justify the individual mandate are too "attenuated" – and thus subject to invalidation under Lopez – because "any market participation by those subject to the Individual Mandate is at least once removed from Congress's purported regulatory target, the healthcare insurance market." No. 3:10-cv-91-RV/EMT, Docket No. 135 at 23. That argument should be rejected. This case could not be further from those, such as Lopez, where the Supreme Court has deemed the inferential chain between the regulated event and the effect on commerce to be too attenuated to support regulation.

In Lopez, the chain of inferences required to connect the regulated event (gun possession in a school zone) to a substantial effect on interstate commerce was long and winding, not to mention unquantifiable. First, one had to assume that firearm possession in a school zone leads to violent crime; second, that guns in schools accordingly "threaten[ ] the learning environment"; third, that the "handicapped educational process" supposedly produced by guns in school zones would "result in a less productive citizenry"; and finally, that this firearm-hampered citizenry would dampen the national economy. Lopez, 514 U.S. at 563-564. Nearly every step in this chain was a matter of conjecture and hypothesis. Here, by contrast, the connection between a lack of pre-financed health care purchases and interstate commerce is immediate and demonstrable: The uninsured

receive health care, and many cannot pay for it out of pocket. As a result, tens of billions of dollars a year in costs are absorbed by third parties, distorting the market. Congress found as much, see 42 U.S.C. § 18091(a)(2)(F), and its findings were not just rational—they were plainly correct. See Mead, 2011 WL 611139, at *16 ("[I]individuals are actively choosing to remain outside of a market for a particular commodity, and, as a result, Congress's efforts to stabilize prices for that commodity are thwarted."). No "inference" is required.

D. Characterizing The Behavior Of The Uninsured As "Inactivity" Misperceives The Court's Task.

The District Court nonetheless found that the uninsured are inactive in the health insurance market and that Congress, through the individual mandate, is regulating "inactivity." Florida, 2011 WL 285683, at *23, *29. But this approach proves too much: Nearly any behavior that has been, or could be, the object of legislative regulation could be characterized as "inactivity." The motel owners in Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964), for example, were "inactive" in the sense that they refused to do something—serve black customers—and were forced to do it by federal law.[15] The farmers in Wickard

[15] It is no answer to say that Heart of Atlanta involved motel owners who, by virtue of having at some point chosen to operate a hotel, were in that sense participating in the stream of commerce. As explained infra at 21-23, activity is a matter of perspective. Uninsured individuals are active in the stream of commerce to the same extent as the motel owners in Heart of Atlanta. Motel owners operate

were "inactive" in the sense that they refused to do something—participate in the public wheat market—and were "forc[ed] * * * into the market to buy what they could provide for themselves." 317 U.S. at 129. And one can imagine a range of other circumstances in which the regulated individual would be "inactive" and yet Congress clearly could regulate. Take, for example, protesters who choose to sit passively at the entrance to nuclear power plants, refusing to move and blocking the way for crucial employees. Surely Congress would be entitled to forbid that "inactivity" if it found that it substantially affected the interstate energy market.

Appellees, no doubt, would respond that all of these examples involve some underlying active component—for example, walking to the nuclear facility to start the protest. But so too here. Uninsured individuals seek and obtain health care services in a massive national market. That is an active component, and one that has a very substantial effect on interstate commerce. Ultimately, whether a regulated individual is sufficiently "active" is a matter of perspective. As the Mead court recognized: "It is pure semantics to argue that an individual who makes a choice to forgo health insurance is not 'acting,' especially given the

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motels; uninsured individuals seek and receive billions of dollars worth of health care services every year.

serious economic and health-related consequences to every individual of that choice." Mead, 2011 WL 611139, at *18.[16]

That fact, in turn, dooms the "inactivity" approach. After all, courts are not in the business of overruling Congress when it comes to characterizing the relevant facts. See Raich, 545 U.S. at 22 ("We need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding."); Wirtz, 392 U.S. at 190 (" '[W]here we find that the legislators * * * have a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce, our investigation is at an end.' ") (quoting Katzenbach v. McClung, 379 U.S. 294, 303-304 (1964)). Thus, "within wide limits, it is Congress—not the courts—that decides how to define a class of activity." Nascimento, 491 F.3d at 42. Here Congress found that the individual mandate "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for[.]" 42 U.S.C. § 18091(a)(2)(A). Congress was entitled to understand the market in that way, just as it was entitled to conclude that motel owners were "active" when they refused service to black customers and that

[16] See also Mead, 2011 WL 611139, at *19 ("[A]s inevitable participants in the health care market, individuals cannot be considered 'inactive' or 'passive' in choosing to forgo health insurance. Instead, as Defendants argue, such a choice is not simply a decision whether to consume a particular good or service, but

Roscoe Filburn was "active" when he refused to buy wheat at retail. The only question for this Court is whether Congress's determination was rational. It was, for all the reasons above.

E. The District Court's Slippery-Slope Hypotheticals Are Inapposite.

The District Court cautioned that if Congress can require participants in the health care market to buy insurance, then "it would be 'difficult to perceive any limitation on federal power,' and we would have a Constitution in name only." Florida, 2011 WL 285683, at *22, *27 (citation omitted). Thus, according to the District Court, Congress could exert unprecedented control over individuals' dietary and transportation decisions—requiring, for example, "that everyone above a certain income threshold buy a General Motors automobile." Id. at *24.

But there is a key difference between the ACA and the hypothetical laws described above: Under the ACA, the activity individuals are being "forced" to undertake[17] is a mere financing mechanism for another activity that they already undertake: consumption of health care. Congress did not make people obtain that underlying product in new or different quantities, and this case does not present the

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ultimately a decision as to how health care services are to be paid and who pays for them.").

[17] Individuals, of course, will not actually be forced to purchase health insurance under the ACA. Those who do not meet an exception (based on income, religious status, or other bases) will instead be assessed a penalty through the tax system if they decline to purchase insurance. See 26 U.S.C. § 5000A(b)(1).

question whether Congress could do so. Instead, Congress made sure people pay for what they get. Put another way, Congress did not make anyone buy a General Motors vehicle. It instead made sure no one can drive a General Motors vehicle off the lot and tell the car dealership to bill their neighbor (or to absorb the cost itself).

The slippery-slope hypotheticals also fail for a second reason: They completely ignore the fact that Congress may not assert a "substantial effect" on interstate commerce via unlikely inferential chains. See Lopez, 514 U.S. at 563-564. For example, the District Court suggested that upholding the ACA could permit Congress to force people to consume a certain amount of broccoli each week merely "because broccoli is healthy."[18] But to assert that the consumption of broccoli substantially affects interstate commerce due to its health benefits is to engage in the same sort of inference-upon-inference logic that was disapproved in Lopez. (As the District Court explained, Florida, 2011 WL 285683, at *24, the logic presumably would be something like: Broccoli is healthy; people who eat healthier tend to be healthier; healthier people are more productive and put less of a strain on the health care system. Compare Lopez, 514 U.S. at 563). For this reason, too, the fact that Congress can regulate financing mechanisms in the nation's largest economic sector hardly means it has unlimited powers.

Finally, these hypotheticals are not just inapposite but unrealistic because they ignore the limits the political process places on Congress's actions. The Supreme Court has recognized for two centuries that while the Commerce Clause power is broad, Congress is restrained by the electorate. Put another way, it has recognized that "effective restraints on [the] exercise" of the Commerce power "must proceed from political, rather than from judicial, processes." Wickard, 317 U.S. at 120 (citing Gibbons v. Ogden, 22 U.S. 1 (9 Wheat.), 197 (1824)). To suggest that Congress would force all Americans to buy a particular make of vehicle, or buy a pound of broccoli every week,[19] or sleep at particular times,[20] or any of the rest of the pundits' parade of fantastical hypotheticals, is to abandon all faith in representative democracy.

III. APPELLEES' MEDICAID ARGUMENTS SHOULD BE REJECTED.

The District Court rejected Appellees' arguments challenging the ACA's expansion of the Medicaid program. To the extent Appellees cross-appeal on that issue, the District Court should be affirmed. Appellees' argument—that any substantial change to Medicaid amounts to "coercion" because they rely on Medicaid's matching funds and cannot extricate themselves—is wrong as a matter

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[18] D. Kam, U.S. judge in Pensacola weighs Florida, 19 other states' challenge of health care law, Palm Beach Post News, Friday, Dec. 17, 2010.

[19] See id.

[20] See id.

of law. The federal courts routinely have held that putting the state to a "hard choice" does not amount to unlawful coercion. If it were otherwise, the states could freeze a federal program, and block Congress from improving it in any way, so long as one participating state happens to rely on the program's funds. Medicaid recipients and health care providers—the two constituencies that interact with and rely on Medicaid the most—would be unable to count on Congress to make the adjustments needed to keep the Medicaid program working fairly over time. That is not a sensible rule of law.

A. Appellees' Coercion Argument Is Wrong On The Law And The Facts.

Numerous courts have rejected the precise argument Appellees made below: that "while [a state's] choice to participate in Medicaid may have been voluntary, it now has no choice but to remain in the program in order to prevent a collapse of its medical system." California v. United States, 104 F.3d 1086, 1092 (9th Cir. 1997). In rejecting that argument, the courts of appeals have explained that "courts are not suited to evaluating whether the states are faced * * * with an offer they cannot refuse or merely with a hard choice." Oklahoma v. Schweiker, 655 F.2d 401, 414 (D.C. Cir. 1981).

Appellees argued below that this case is different because the ACA amends Medicaid in a way past modifications did not. They asserted that "[w]here Medicaid originally was supposed to address healthcare needs of the poor, the

ACA requires that States cover virtually anyone who applies and whose income is up to 38 percent above the federal poverty line." No. 3:10-cv-91-RV/EMT, Docket No. 80-1 at 26 (emphases in original).[21] They claimed that under the original Medicaid scheme, states could " 'choose to reimburse certain costs of medical treatment for needy persons,' " id. (quoting Harris v. McRae, 448 U.S. 297, 301 (1980)) (emphases in original), and that that approach has changed. And they characterized the many Medicaid amendments of the past as "minor revisions," contending that the ACA, by contrast, "revolutionizes [the] program." Id. at 38.

But these arguments are both irrelevant and factually incorrect. They are irrelevant because to the extent the "coercion" doctrine suggested by South Dakota v. Dole, 483 U.S. 203 (1987), is judicially enforceable, the relevant coercion logically must arise from the funding Congress holds out as a carrot, not from the particulars of the program Congress encourages the states to enact.

They are incorrect because they mischaracterize both past Medicaid amendments and the changes wrought by ACA. The Medicaid statute has long required states to cover certain categories of Medicaid beneficiaries—as opposed to letting the states "choose," No. 3:10-cv-91-RV/EMT, Docket No. 80-1 at 26

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[21] Thirty-eight percent above the federal poverty line for a family of four is $30,429. The poverty line does not mean that everyone who lives above that line is financially secure.

(quotation omitted)—and has long required payments on behalf of individuals with incomes "above the federal poverty line." Id. With respect to coverage requirements, for example, 1972 Medicaid amendments "[r]equired states to extend Medicaid to SSI recipients or to elderly and disabled" people meeting certain eligibility criteria. Kaiser Comm'n on Medicaid & The Uninsured, The Medicaid Resource Book 175 (App'x 1) (2002).[22] A 1984 amendment "[r]equired states to cover children born after September 30, 1983, up to age 5, in families meeting state AFDC income and resource standards." Id. And since 1991, states have been "required to cover all children over the age of five and under 19 who are in families with income below 100% of the federal poverty level." Congressional Res. Serv., How Medicaid Works: Program Basics 4 (2005).[23] With respect to the income criteria, amendments enacted between 1986 and 1991 "require [states] to cover pregnant women and children under age 6 with family incomes below 133% of the federal poverty income guidelines"—the very threshold the plaintiff states present as a revolutionary change. Id. at 3-4. And a 1990 amendment "[r]equired states to phase in coverage of Medicare premiums for low-income Medicare beneficiaries with incomes between 100 and 120 percent of poverty." Medicaid

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[22] Available at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14255.

[23] Available at http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3227703162005.pdf.

Resource Book 176. These are just a few of many eligibility mandates—including directives to cover individuals with income (marginally) above the federal poverty threshold—that have been in place for decades. Appellees' attempt to portray ACA's coverage mandates as a "revolutionary" break from the past is simply counterfactual.

B. Plaintiffs' Argument Has Dangerous Ramifications That Could Prove Devastating For Hospitals And Their Patients.

Finally, it is important to understand the practical consequences of the doctrine the states advance: If their theory were law, Congress could not adjust Medicaid to respond to changes on the ground—demographic developments, innovations in the medical delivery system, and the like—unless every participating state agreed to Congress's proposed modification.

Congress has seen fit to modify Medicaid dozens of times over the decades to expand eligibility, expand or contract states' flexibility regarding coverage and payments, and ensure that healthcare providers are fairly compensated when they treat Medicaid recipients. In 1980, for example, Congress enacted the "Boren Amendment" (later repealed), which required states to pay " 'reasonable and adequate' payment rates" to healthcare providers for the nursing home and hospital services they offer to Medicaid patients. Medicaid Resource Book 175; see Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499. And as noted above, between 1986 and 1991, Congress amended Medicaid to require states to cover

pregnant women and young children with family incomes below 133% of the federal poverty level. How Medicaid Works 3-4.

Congress presumably enacted these and many similar modifications because it became convinced, in light of developments in the health care industry, that they were necessary to keep the system running smoothly and fairly. But if the states' "coercion" theory were credited, any one participant state could have blocked all of these improvements—or, perhaps more likely, could have blocked the ones that increased the state's costs and allowed others to stand.

This heckler's veto, of course, flips the Constitution on its head. See M'Culloch v. Maryland, 17 U.S. 316, 330 (1819) (rejecting the suggestion "that congress can only exercise its constitutional powers, subject to the controlling discretion, and under the sufferance, of the state governments"). But it also has the potential to wreak havoc on America's hospitals and the patients they serve. If Congress were to determine, for example, that hospitals are being undercompensated for treating a category of Medicaid patients, or that certain Medicaid recipients need additional services, it must have the prerogative to revise the program accordingly. The patients have nowhere else to turn for treatment, and the healthcare providers have nowhere else to turn for payment. Congress's best judgment on these matters cannot be held hostage at the whim of some objecting states.

CONCLUSION

Hospitals will continue to care for the uninsured, as they have for generations, regardless of their ability to pay—and indeed, for many hospitals that service is at the core of their mission. But let there be no mistake: The choice to forgo health insurance is not a "passive" choice without concrete consequences. The health care uninsured Americans obtain has real costs. Their decision to obtain care, and how to pay for it, is economic activity with massive economic effects, including the imposition of billions in annual costs on the national economy. In regulating the national health care industry, Congress possessed ample authority to address those costs by changing the way uninsured Americans finance the services they receive and expanding the Medicaid program.

The District Court's judgment should be reversed as to the individual mandate and affirmed as to the ACA's expansion of Medicaid.

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that this brief contains 6,996 words, excluding the portions of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and has been prepared in a proportionally spaced typeface using Microsoft Word 2003 in Times New Roman 14-point font.

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CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of April, 2011, I filed the foregoing Brief for Amici Curiae by causing paper copies to be delivered to the Court by Federal Express. I also hereby certify that, by agreement with counsel, I caused the brief to be served by electronic mail upon the following counsel:

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