IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

STATE OF FLORIDA, by and through BILL McCOLLUM, *et al.*,	)	
Plaintiffs,	)	
v.	)	Case No. 3:10-cv-91-RV/EMT
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,	)	Judge Roger Vinson
Defendants.	)	

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THE AMERICAN HOSPITAL ASSOCIATION ET AL.

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November 19, 2010

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BRIEF AMICI CURIAE OF
THE AMERICAN HOSPITAL ASSOCIATION ET AL.

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.

STATEMENT OF INTEREST

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 approximately 300 major non-federal teaching hospitals, all 133 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 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 throughout the United States. 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 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 2008 alone, hospitals provided more than $35 billion in uncompensated care to the uninsured and under-insured. American Hosp. Ass'n, Uncompensated Care Cost Fact Sheet 4 (Nov. 2009) ("Fact Sheet");[1] 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

[1] Available at http://www.aha.org/aha/content/2009/pdf/09uncompensatedcare.pdf.

The Uninsured").[2] 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.

That is why the Hospital Associations favored enactment of the Patient Protection and Affordable Care Act ("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.

ARGUMENT

I. UNINSURED AMERICANS' PARTICIPATION IN THE HEALTH CARE MARKET CANNOT FAIRLY BE CHARACTERIZED AS "INACTIVITY."

Plaintiffs' individual-mandate argument is premised on the notion that, by requiring many Americans to obtain health insurance, Congress is regulating "inactivity." Docket No. 80-1 at 5-9 (Mem. in Supp. of Pls.' Mot. for Summ. J.) (Nov. 4, 2010) ("Pl. Br."). Thus plaintiffs describe individuals without health insurance as "passive," id. at 9, and as engaging merely in the "mental process" of declining to purchase insurance. Id. at 10.

This argument fails for at least two reasons. First, it is irrelevant: The "individual mandate" or "minimum coverage" provision is an important component of the ACA's comprehensive regulatory reforms to the interstate health care and health insurance markets. Docket No. 82-1 at 12-24 (Mem. in Supp. of Defs.' Mot. for Summ. J.) (Nov. 4, 2010) ("U.S. Br."). Congress has the authority to regulate behavior where, as here, a failure to do so "would undermine Congress's ability to implement effectively the overlying economic regulatory scheme." United States v. Maxwell, 446 F.3d 1210, 1215 (11th Cir. 2006); see also U.S. Br. 13-14, 23-24. Because it plays an integral role in facilitating Congress's regulation of interstate

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

markets, the individual mandate is a valid exercise of Congress's Commerce Clause authority and its authority under the Necessary and Proper Clause. U.S. Br. 12-24.

Second, and in any event, uninsured Americans unquestionably participate in relevant economic activity: They obtain health care services. Indeed, they 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 how he will pay (or make others 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 individual mandate falls comfortably within Congress' authority to regulate interstate commerce. See U.S. Br. 24-26.

Plaintiffs can assert that the uninsured are "passive," and engaged in a mere "mental process," only by focusing exclusively on the health insurance market and ignoring the broader market Congress also chose to regulate through the ACA—the health care market. See ACA § 1501(a)(1). The Court should reject this invitation to redefine the lens through which Congress viewed its own regulatory task. 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 Gonzales v. Raich, 545 U.S. 1, 22 (2005)).

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 make a decision as to how to finance these costs. That decision is economic activity, and the individual mandate regulates this marketplace behavior. See U.S. Br. 24-26.

1. Simply stated, uninsured Americans are engaged in economic activity because they seek and obtain large amounts of health care. 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 8-9. 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).[3] 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).[4] 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. O'Neill et al., Who Are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics and Their Health 21 & Table 9 (2009).[5] 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 forgo health insurance is

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

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

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

an economic decision directly related to the services they routinely receive. It is a decision about how to pay—or make others pay—for services rendered.

2. Plaintiffs resist the import of this economic activity, arguing that Americans have "the freedom to declare themselves 'out' " of the health care market and "the freedom to refuse health care services," just as they have the freedom to avoid the markets for goods such as transportation and communications. Pl. Br. 11. But health care is not a consumer good like a car or a cellphone. Nearly all people, sooner or later, will 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 receive. Accordingly, plaintiffs' concession that Congress may regulate individuals who enter the market, Pl. Br. 11, is fatal to their case: In health care, nearly everyone enters the market, regardless of whether they purchase insurance.[6] By choosing to forgo insurance, individuals simply shift the burden of their health care payments to others. See infra at 8-11. The health care market is unique in these respects, and plaintiffs' invocations of other markets, like transportation and entertainment, are inapposite. This combination—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.

Plaintiffs' "passivity" argument also obscures an important reality: The decision of some uninsured individuals to put off regular preventive care actually increases their activity in the

[6] That some small percentage of Americans never receives health care does not change the constitutional calculus. Congress may consider and regulate the market in the aggregate. See Raich, 545 U.S. at 22 (explaining that a regulation is permissible under the Commerce Clause so long as a "rational basis" exists for concluding that the regulated "activities, taken in the aggregate, substantially affect interstate commerce"); Wickard v. Filburn, 317 U.S. 111 (1942).

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).[7] 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 Higher for the Uninsured, HealthLeaders Media (June 14, 2010).[8] For this reason, too, it makes little sense to say that people can "declare themselves 'out' " of the health care market. Pl. Br. 11. Any decision to avoid that 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.[9]

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

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

[9] It is important to note that plaintiffs exaggerate the burden the individual mandate purportedly imposes on the uninsured. Some 90 percent of those subject to the mandate will receive free or subsidized care under ACA. Those under 133 percent of the Federal Poverty Level ("FPL") will

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

Uninsured Americans thus 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 against their behavior by virtue of the Commerce Clause and the Necessary and Proper Clause. See U.S. Br. 23-24.

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, 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

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be fully covered by Medicaid. ACA § 2001(a)(1). For those earning up to 400 percent of the FPL, the federal government will subsidize a substantial portion of the premiums. U.S. Br. 40.

[10] This is derived by subtracting $30 billion in uninsured self-payment from the $86 billion total. See supra at 5, 8. 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.

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 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 (e.g., 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 that 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

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

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

[whose] hospital bills exceed a certain proportion of their annual household income or assets." Id. at 11. For 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.

* * *

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.

II. THE STATES' MEDICAID ARGUMENTS SHOULD BE REJECTED.

The plaintiff states assert that because they have come to rely on Medicaid's federal matching funds, they cannot extricate themselves if Congress changes the program in ways they do not like. Thus, they say, any substantial change to Medicaid amounts to "coercion."

As explained at length in the Government's memorandum, that argument is wrong as a matter of law. U.S. Br. 38-50. It also has disturbing implications for the constituencies—Medicaid recipients and healthcare providers—that interact with and rely on Medicaid the most. If plaintiffs' theory were correct, then 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. Hospitals and patients would be unable to count on Congress to make the adjustments needed to keep the Medicaid program working fairly over time.

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

Numerous courts have rejected the precise argument plaintiffs make here: 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); compare Pl. Br. 33 (arguing that states are coerced because they could not "make up th[e] shortfall" if they withdrew from Medicaid). 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).

Plaintiffs, however, assert that circumstances have changed because the ACA amends Medicaid in a way past modifications did not. They assert 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." Pl. Br. 26 (emphases in original).[15] They emphasize 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 plaintiffs' memorandum). And they characterize the many Medicaid amendments of the past as "minor revisions" and say that the ACA, by contrast, "revolutionizes [the] program." Id. at 26.

This argument fails for two reasons. First, it is (once again) irrelevant. To the extent the "coercion" doctrine suggested by South Carolina 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.

Even putting that problem aside, however, the argument still fails because it mischaracterizes 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," Pl. Br. 26—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

[15] 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.

Comm'n on Medicaid & The Uninsured, The Medicaid Resource Book 175 (App'x 1) (2002).[16] 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).[17] 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 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. Plaintiffs' 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' proposed modification.

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

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

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 177; see Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499. In 1981, Congress enacted a provision requiring states to make payment adjustments to hospitals serving a disproportionate share of Medicaid and low-income patients. Medicaid Resource Book 175; see Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35. 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. After all, states have long received substantial federal matching funds under Medicaid. See generally Schweiker, 655 F.2d 401. Thus the plaintiff states' theory that they are "forced" to participate in Medicaid, and that any new requirement of which they disapprove constitutes coercion, applies equally to every significant Medicaid modification Congress has ever seen fit to enact. None could have become law if any of the 50 states had thought the better of it.

This heckler's veto, of course, flips the Constitution on its head. See Bartkus v. People of State of Ill., 359 U.S. 121, 156 (1959) ("[I]n matters properly within its scope" the federal government "is supreme"). 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' best judgment on these matters cannot be held hostage at the whim of some objecting states.

CONCLUSION

For years, America's hospitals have worked to make significantly expanded health care coverage for all a reality. By providing coverage to 32 million additional people, the ACA moves the nation further in that direction. This historic achievement will make a real difference in the lives of millions of Americans—and it was within Congress' power to enact.

For the foregoing reasons, the Court should enter judgment in favor of the federal government.

Respectfully submitted,

/s/ Catherine E. Stetson

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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of November 2010, a true and correct copy of the foregoing Brief Amici Curiae of the American Hospital Association et al. was served electronically on all counsel of record by filing the document through the Northern District of Florida Electronic Case Filing system.

/s/ Catherine E. Stetson
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