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Seven-Sky v. Holder - Amicus Brief of American Hospital Association et al.

American Hospital Association

[ORAL ARGUMENT SCHEDULED FOR SEPTEMBER 23, 2011]

No. 11-5047

IN THE

United States Court of Appeals for the District of Columbia Circuit

SUSAN SEVEN-SKY, et al.,
Plaintiffs-Appellants,

v.

ERIC H. HOLDER, JR., et al.,
Defendants-Appellees.

On Appeal from the United States District Court
for the District of Columbia No. 1:10-cv-0950 (Kessler, J.)

CORRECTED BRIEF AMICI CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION ET AL. IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(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 certify the following:

Parties and Amici. All parties, intervenors, and amici appearing before the district court and in this Court are listed in the Briefs for Appellants and Appellees. The Corporate Disclosure Statement required by Circuit Rule 26.1 immediately follows this Certificate.

Rulings Under Review. The decision on appeal is Judge Gladys Kessler's February 22, 2011 memorandum opinion and order granting the United States' motion to dismiss. JA 101-166; Mead v. Holder, No. 1:10-cv-0950, __ F. Supp. 2d __, 2011 WL 611139 (D.D.C. Feb. 22, 2011).

Related Cases. This case has not previously been before this Court or any court other than the district court from which this case has been appealed. Counsel for amici are not aware of any related cases pending in this Court within the meaning of Circuit Rule 28(a)(1)(C). The following are related cases pending in other U.S. courts of appeals and in courts in the District of Columbia:

Courts of Appeals

Baldwin v. Sebelius,
No. 10-56374 (9th Cir.)

Florida ex rel. Bondi v. U.S. Department of Health & Human Services,
Nos. 11-11021 & 11-11067 (11th Cir.)

Kinder v. Geithner,
No. 11-1973 (8th Cir.)

Liberty University, Inc. v. Geithner,
No. 10-2347 (4th Cir.)

New Jersey Physicians, Inc. v. President of the United States,
No. 10-4600 (3d Cir.)

Purpura v. Sebelius,
No. 11-2303 (3d Cir.)

Thomas More Law Center v. Obama,
No. 10-2388, slip op. (6th Cir. June 29, 2011)

U.S. Citizens Association v. Sebelius,
No. 11-3327 (6th Cir.)

Virginia ex rel. Cuccinelli v. Sebelius,
Nos. 11-1057 & 11-1058 (4th Cir.)

District of Columbia

Association of American Physicians & Surgeons, Inc. v. Sebelius,
No. 1:10-cv-499 (D.D.C.)

Sissel v. U.S. Department of Health & Human Services,
No. 1:10-cv-1263 (D.D.C.)

RULE 26.1 CERTIFICATION

Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1, 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 statement:

Each of the above-named amici is a nonprofit association representing America's hospitals.

1. Are the amici publicly held corporations or other publicly held entities? No.

2. Do the amici have any parent corporations? No.

3. Is 10% or more of the stock of any amici owned by a publicly held corporation or other publicly held entity? No.

4. What is the general nature and purpose of the amici? As described in the Statement of Interest, infra, at 1-4. All amici are professional associations under Circuit Rule 26.1(b).

/s/ Catherine E. Stetson
Catherine E. Stetson

CERTIFICATE IN SUPPORT OF SEPARATE BRIEF

Under Circuit Rule 29(d), "[a]mici curiae on the same side must join in a single brief to the extent practicable." Counsel for amici certifies that this separate brief is necessary to share the unique perspective of the nation's hospitals, which treat tens of millions of uninsured patients every year. As far as counsel for amici is aware, this perspective will not otherwise be captured in any depth by any party or any other amicus in this Court. Counsel for amici further certifies that the amici have joined together to the extent practicable insofar as this brief features the consolidated views of six independent hospital associations.

/s/ Catherine E. Stetson
Catherine E. Stetson

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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]

[1] Pursuant to Federal Rule of Appellate Procedure 29, amici certify that all parties

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 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

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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 intended to fund the brief's preparation or submission.

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 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.

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.

[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.

ARGUMENT

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

Appellants' individual-mandate argument is premised on the notion that, by requiring many Americans to obtain health insurance, Congress is regulating "inactivity." Appellants' Br. ("App. Br.") 18-19. They repeatedly describe the individual mandate as regulation of "mere 'mental activity' or decisions," id. 22 (emphasis removed), and assert that "decisions [that] lead to non-economic activity, or inactivity, . . . [are] not within Congress's power to regulate." Id. 19. This contention has been flatly rejected by the Sixth Circuit. See Thomas More Law Ctr. v. Obama, ___ F.3d ___, 2011 WL 2556039 (6th Cir. June 29, 2011) ("Thomas More").[4] And it fails 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 ("U.S. Br.") 22-36, 42-52.

First, appellants' contention that "activity" is an independent requirement of congressional regulation under the Commerce Clause is mistaken. See Thomas More, 2011 WL 2556039, at *43 (Sutton, J., concurring) ("Does the Commerce Clause contain an action/inaction dichotomy that limits congressional power? No[.]"). Though appellants strive mightily to suggest otherwise, the Supreme

[4] Unless otherwise indicated, all subsequent citations to Thomas More are to Judge Martin's opinion.

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").[5] 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 Machine Co. v. Davis, 301 U.S. 548, 589-590 (1937), because whether a regulated individual is engaged in relevant activity

[5] Appellants mistakenly contend that Raich is distinguishable in part because it involved an as-applied challenge rather than a facial challenge like this case. App. Br. 27-28. But if it means anything, that distinction counsels in favor of the Government here; for the burden faced by appellants in this proceeding is greater than that faced by the plaintiffs in Raich. See Nebraska v. EPA, 331 F.3d 995, 998 (D.C. Cir. 2003) (holding that, in order to make a successful Commerce Clause challenge to a statute on its face, one "must show that the Act would be constitutional under 'no set of circumstances' ") (citation omitted).

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 Thomas More, 2011 WL 2556039, at *14 ("Congress had a rational basis for concluding that the minimum coverage requirement is essential to its broader reforms to the national markets in health care delivery and health insurance."). 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) ("It is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole satisfies this test."). 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.

For both of these reasons, appellants' challenge to the ACA fails. But amici wish to focus in greater detail on a third, independent reason why this Court should affirm: 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.

Appellants can assert that the uninsured are passive and engaged in mere "inactivity" only by focusing exclusively 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.[6] 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).

[6] In any event, the health insurance market and the health care market are inextricably linked. As the Sixth Circuit recently acknowledged, "the practice of self-insuring substantially affects interstate commerce by driving up the cost of health care as well as by shifting costs to third parties." Thomas More, 2011 WL 2556039, at *12. Specifically, the cost of uncompensated care is passed on from providers to private insurers, which results in "[r]ising premiums" that "push even more individuals out of the health insurance market, further increasing the cost of health insurance and perpetuating the cycle." Id.; see also id. at *39 (Sutton, J., concurring) ("Congress found that providing uncompensated medical care to the uninsured cost $43 billion in 2008 and that these costs were shifted to others through higher premiums."). In sum, efforts to regulate payment in the health care market invariably will affect the health insurance market and vice versa.

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.

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 14-15. 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).[7] 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

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

Signs: Access to Health Care (Nov. 9, 2010).[8] 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 Population, Their Characteristics and Their Health 21 & Table 9 (2009) ("Who Are The Uninsured").[9] 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.

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

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

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 receive.[10] By forgoing insurance, individuals simply shift the burden of their health care payments to others. See infra at 14-18. 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.

3. Appellants' argument that the uninsured are simply "declining to enter a commercial transaction," App. Br. 18, and are engaging in no "relevant current economic or commercial activity," id. at 33, 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.

[10] 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, 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.

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).[11] 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

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

preventive services." E. Bakhtiari, In-Hospital Mortality Rates Higher for the Uninsured, HealthLeaders Media (June 14, 2010).[12] For this reason, too, it makes little sense to suggest that people can declare themselves out of the health care market. See App. Br. 22-23, 34-36. 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.[13]

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

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

[13] It is important to note that appellants 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 be fully covered by Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). For those earning up to 400 percent of the FPL, the federal government will subsidize a substantial portion of the premiums. U.S. Br. 14.

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, doctors, clinics, and health-care systems.[14] 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).[15] 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).[16] 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

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

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

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

Endangered (2000).[17] 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," 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).[18] 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.

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

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 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

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

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.

Appellants ignore all of the data demonstrating that (i) the overwhelming majority of uninsured Americans obtain health care and (ii) the bulk of that tab is picked up by health care providers and taxpayers. Instead of confronting it, they assert repeatedly, and without citation, that Congress cannot regulate the class of uninsured individuals merely because "a small subset of that group will, at some point in the future," obtain uncompensated health care. App. Br. 6, 30 n.6, 31 (emphasis added). That "small subset" assertion is simply wrong—and the fact that appellants feel the need to resort to inaccuracy is telling. In regulating uncompensated care, Congress did not visit the sins of a few upon many, as appellants suggest. Congress instead recognized—correctly—that most care for the uninsured goes uncompensated, and that the problem is national in scope. Congress was entitled to devise a national remedy.

C. Appellants' Attempt To Analogize This Case To Lopez Fails.

Appellants suggest that in Lopez the Court rejected out of hand the Government's costs-based justification for the statute at issue. App. Br. 15. But appellants mischaracterize the Lopez decision and fail to acknowledge the Court's underlying reasoning. Had they done so, it would be apparent that 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.

In Lopez, the Court determined that there was an insufficient nexus between the challenged criminal statute and interstate commerce. Specifically, the chain of inferences required to connect the regulated event (gun ownership 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 Thomas More, 2011 WL 2556039, at *12 ("Self-insuring for the cost of health care directly affects the interstate market for health care delivery and health insurance. These effects are not at all attenuated as were the links between the regulated activities and interstate commerce in Lopez[.]"); id. at *39 (Sutton, J. concurring) ("Based on these findings, Congress could reasonably conclude that the decisions and actions of the self-insured substantially affect interstate commerce."). No "inference" is required.

D. Appellants' Attempt To Characterize The Behavior Of The Uninsured As "Inactivity" Misperceives The Court's Task.

Appellants nonetheless insist that the uninsured are inactive in the health insurance market, that Congress is "forcing" them to participate, and that such forced participation represents an "unprecedented line of reasoning" that "Congress can * * * use its Commerce Clause power to require individuals who are not engaging in a particular economic activity to do so[.]" App. Br. 22-25, 29, 34. But appellants' 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.[19] The farmers in Wickard 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.

Appellants, 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. Appellants' argument thus

[19] 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 20-23, 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 motels; uninsured individuals seek and receive billions of dollars worth of health care services every year.

merely underscores the fact that whether a regulated individual is sufficiently "active" is a matter of perspective. As the Sixth Circuit recognized: "The activity of foregoing health insurance and attempting to cover the cost of health care needs by self-insuring is no less economic than the activity of purchasing an insurance plan. Thus, the financing of health care services, and specifically the practice of self-insuring, is economic activity." Thomas More, 2011 WL 2556039, at *11. See also id. at *45 (Sutton, J., concurring) ("[I]naction is action, sometimes for better, sometimes for worse, when it comes to financial risk. * * * No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk.") (emphasis in original).

That fact, in turn, dooms their case. 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 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. Appellants' Slippery-Slope Hypotheticals Are Inapposite.

Finally, appellants turn to a tactic ACA opponents consistently have relied upon: They insist that if Congress can require participants in the health care market to buy insurance, then Congress effectively will be permitted to exercise a "federal police power allowing Congress—for the first time—to mandate a host of purchases by individuals." App. Br. 17. According to appellants, Congress's assertion of authority in the ACA means it could also "mandate that all Americans above a certain income level buy a General Motors vehicle" or "requir[e] Americans to buy a gym membership, keep a specific body weight, or maintain a healthier diet[.]" Id. 38-39, 42.

Not so. There is a key difference between this case and the hypothetical laws appellants describe: In this case, the activity individuals are being "forced" to undertake[20] 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 question whether Congress could do so. Instead, Congress made sure people pay for what they get. To put things in appellants' terms, 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).[21]

Appellants' 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.

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[20] Appellants, of course, will not actually be forced to purchase health insurance under the ACA. They will instead be assessed a penalty through the tax system if they decline to purchase insurance. See 26 U.S.C. § 5000A(b)(1).

[21] Analogies to the auto industry also help to underscore the unusual nature of the health care industry. In the auto industry—as in most industries—consumers who want goods or services must pay or at least commit to a payment plan. That is not the case in the health care industry. See supra at 11-12. The individual mandate merely seeks to address the problems arising from this unique situation. As Judge Sutton observed: "Regulating how citizens pay for what they already receive (health care), never quite know when they will need, and in the case of severe illnesses or emergencies generally will not be able to afford, has few (if any)

Appellants, for example, suggest that Congress could force people to maintain a healthier diet on the theory that these actions are "necessary to improve health and lengthen life expectancies[.]" App. Br. 42. But to assert that a preference for unhealthy foods (for instance, fast food) over healthy foods (for instance, vegetables) among some subset of the population substantially affects interstate commerce is to engage in the same sort of inference-upon-inference logic that was disapproved in Lopez. (The logic presumably would be something like: Everyone has to eat, and vegetables are more healthful than fast food; people who dislike vegetables consume too much fast food and not enough vegetables; such a diet can lead to disease; such disease raises health-care costs. 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 a "federal police power." App. Br. 49.

Finally, appellants' alarmist 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

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parallels in modern life." Thomas More, 2011 WL 2556039, at *32 (Sutton, J., concurring).

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,[22] or sleep at particular times, [23] or any of the rest of the pundits' parade of fantastical hypotheticals, is to abandon all faith in representative democracy.

[22] See 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.

[23] See id.

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.

The District Court's judgment should be affirmed.

Respectfully submitted,

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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 complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because the brief contains 6,093 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because the brief has been 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 6th day of July, 2011, the foregoing Corrected Brief was filed with the Court's ECF system, and accordingly was served electronically on all parties.

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