No. 11-398

IN THE
Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,
Petitioners,
v.
FLORIDA, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF PETITIONERS WITH RESPECT TO THE INDIVIDUAL MANDATE

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STATEMENT OF INTEREST[1]

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 respectfully submit this brief as *amici curiae*.

[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund the brief's preparation or submission. No one other than *amici* or their members or counsel made a monetary contribution to the brief. All parties filed blanket *amicus* consent letters.

The American Hospital Association 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 represents about 300 major non-federal teaching hospitals, all 136 accredited medical schools, and the clinical faculty and medical residents who provide care to patients there.

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Federation of American Hospitals is the representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and Washington D.C. 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 supports its 221 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. Medicaid is the single largest insurer of children and the largest payer for children's hospitals. On average, 50 percent of the patients at children's hospitals are enrolled in Medicaid.

The National Association of Public Hospitals and Health Systems 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. 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, and as part of that mission they dedicate massive resources to caring for the uninsured. 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 the last decade, hospitals provided more than *$300 billion* in uncompensated care to the uninsured and under-insured. American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 4 (Jan. 2012)[2]; *see also* J. Hadley *et al.*, *Covering The*

[2] *Available at* http://www.aha.org/content/12/11-uncompensated-care-fact-sheet.pdf.

Uninsured In 2008: Current Costs, Sources of Payment, & Incremental Costs 403, Health Affairs, Aug. 25, 2008 ("*Covering The Uninsured*").[3] And although hospitals do what they can to assist patients, burdens on uninsured individuals remain heavy. Millions of families are just one major injury or illness from financial ruin.

That is why the Hospital Associations favored enactment of the Patient Protection and Affordable Care Act ("ACA"). The legislation extends coverage to millions more Americans. To undo it now would be to maintain an unacceptable status quo—a result that is neither prudent nor compelled by the Constitution.

SUMMARY OF ARGUMENT

1. This Court should uphold the individual mandate for a simple reason: The way uninsured Americans pay—or are unable to pay—for the health care they consume "substantially affects" interstate commerce. *United States* v. *Lopez*, 514 U.S. 549, 559 (1995). Indeed, to use that term of art is to engage in massive understatement. Some 50 million Americans lack health insurance, the vast majority of them receive health care, and that care costs tens of billions of dollars each year. That cost is borne, in large measure, by third parties, including hospitals and health care systems as well as American taxpayers. On these facts, as the D.C. Circuit recognized, the "substantial effect" on interstate commerce is obvious: "Congress reasonably determined that as a *class*, the uninsured create market failures" that

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

justify regulating how they finance the health care they receive. *Seven-Sky* v. *Holder*, 661 F.3d 1, at *20 (D.C. Cir. 2011).

The Eleventh Circuit reached the contrary conclusion, reasoning that any link between the uninsured and interstate commerce is too attenuated because "[a]t best, we can say that the uninsured *may*, at some point in the *unforeseeable future*, create [a] cost-shifting consequence." Pet. App. 134a. That is a demonstrably incorrect statement. The economic activity undertaken by the uninsured creates a well-documented "cost-shifting consequence"—and a massive one at that—that distorts the health care and insurance markets by billions of dollars a year. The Eleventh Circuit's holding thus either rests on a false premise or entirely fails to recognize that Congress can regulate economic activity "in the aggregate," *Gonzales* v. *Raich*, 545 U.S. 1, 22 (2005), or both. Either way, its decision is fatally flawed. It should be reversed.

2. The Courts of Appeals roundly rejected respondents' proposed "activity" requirement for Commerce Clause regulation. This Court should do the same. The requirement has no basis in law and is unworkable to boot. But even if "activity" were required, the requirement would be met here because uninsured Americans unquestionably *do* participate in relevant economic activity: They obtain massive quantities of health care services for which they cannot or do not pay. The "activity" argument fails on its own terms.

3. Respondents argued below that if Congress can mandate the purchase of health insurance, then it could make Americans purchase anything, from cars to broccoli. Those arguments fall flat because the

purchase the ACA mandates—insurance—is a mere financing mechanism for another product the uninsured *already* consume—health care. Congress did not make people obtain that underlying product in new or different quantities. In that way, as the D.C. Circuit recognized, health care is unique. This case cannot be resolved based on facile comparisons to dissimilar markets.

ARGUMENT

I. THE CRISIS OF UNINSURANCE SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE.

The fundamental question in this case is whether "the national problem Congress has identified"—namely, the crisis of uninsurance—"is one that substantially affects interstate commerce." *Seven-Sky*, 661 F.3d 1, at *19. The answer clearly is yes: America's tens of millions of uninsured residents consume tens of billions of dollars' worth of health care each year. Others pick up much of the cost. The result is extreme distortion of both the health care and health insurance markets. That is a substantial effect if ever there was one.

A. The Uninsurance Crisis Substantially Affects Interstate Commerce.

1. In 2008 alone, uninsured Americans received $86 billion worth of health care from all providers. *Covering The Uninsured* 399, 402-403. The uninsured also made more than 20 million trips 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).[4]

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

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).[5] Approximately 50 million people fell into this category over the course of 2010. *Id.*

The vast majority of these millions of uninsured individuals seek and receive health care services at some point—a point the lower courts repeatedly have recognized. *See Thomas More Law Center* v. *Obama*, 651 F.3d 529, 545 (6th Cir. 2011) ("virtually every individual in this country consumes these services"); *Seven-Sky*, 661 F.3d 1, at *18 ("virtually everyone" participates in the health care market); *see also* 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 & tbl.9 (2009).[6] 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 & tbl.9. The takeaway is simple enough: "[T]he uninsured receive significant amounts of healthcare[.]" *Id.* at 24.

2. And those services are costly. As mentioned above, the uninsured pay a portion of the bill them-

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

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

selves. *Covering The Uninsured* 399. But the bulk of the cost is borne by hospitals, health systems, doctors, insurers, and even other patients.

To begin with the providers: Of the $86 billion in care the uninsured received in 2008, some $56 billion was in the form of uncompensated care provided by hospitals, doctors, clinics, and health-care systems. *Id.* That amount 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.[7] All hospitals and health care systems—public and private, urban and rural, teaching and children's, investor-owned and nonprofit—shoulder these uncompensated-care costs. 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).[8] For these hospitals, uncompensated care amounts to some 21 percent of total costs. *See* Changes in Health Care Financing & Organization, *Challenges Facing the Health Care Safety Net* (Feb. 2008).[9]

3. To be sure, hospitals bear many of these expenses as part of their mission. But that does not change

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

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

[9] *Available at* http://www.hcfo.org/publications/challenges-facing-health-care-safety-net.

the fact that uninsured individuals' collective need to seek care causes a substantial—indeed, massive—effect on interstate commerce.

A description of how hospitals work to serve uninsured patients illustrates how the crisis of uninsurance shifts costs to hospitals, and eventually to everyone in the health care market. Nearly every hospital with an emergency department is required to provide emergency services to anyone, regardless of ability to pay, at least until the patient's condition stabilizes. *See* Emergency Medical Treatment and Active Labor Act of 1986, 42 U.S.C. § 1395dd. State statutes and common-law rules also impose these duties in many jurisdictions. *See* U.S. Br. 39. As the Government rightly notes, these statutory duties reflect "deeply ingrained societal norms" that obligate health care providers to treat and stabilize those in need of emergency assistance. *Id.* That emergency care is often very costly. Trauma care, for example, requires hospitals to dedicate massive resources that, in serious cases, can quickly produce costs in the tens of thousands, or even hundreds of thousands, of dollars per patient. *See* P. Gerepka, *Cost Benefit Analysis of Providing Level II Trauma Care at William Beaumont Army Medical Center (WBAMC)* 12 (2002).[10] And hospitals, of course, must maintain sufficient emergency staff and equipment to serve the *whole* population, not just those who are insured. The costs are huge—and the majority of the bill goes unpaid. *See* U.S. Br. 8.

But even when the patient's need does not rise to the level of an emergency, hospitals regularly pro-

[10] *Available at* http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA421102.

vide 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).[11] 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. The simple fact is that the machines, medicines, and technologies required to practice modern medicine are expensive—which is why, as the Government observes, the average bill for a single hospital stay for an uninsured person is some $22,500, and many procedures cost far more. *See* U.S Br. 8, 36. That is beyond the means of most American families.

Hospitals do what they can to help. Despite their incomes, some of these uninsured individuals 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." *Patient Friendly Billing Project* at 11. For others, hospitals offer financial counseling, flexible payment plans, interest-free loans, and initiatives that help patients

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

apply for grants or Medicaid. *Id.* at 11-15. These services advance hospitals' missions to serve the community—but they also require substantial resources that add to the already massive costs hospitals absorb to treat the uninsured.

Hospitals and other health care providers do not shoulder the burden alone. Supplemental Medicare and Medicaid payment programs also fund care for the uninsured and under-insured—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 a 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. Congress determined that cost "is passed on * * * 'to private insurers, which pass on the cost to families.' " *Thomas More*, 651 F.3d at 545 (quoting 42 U.S.C. § 18091(a)(2)(F)). "This cost-shifting inflates the premiums that families must pay for their health insurance 'by on average over $1,000 a year.' " *Id.* And " '[r]ising premiums push even more individuals out of the health insurance market, further increasing the cost of health insurance and perpetuating the cycle.' " *Id.* (quoting *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. 49 (2008) (statement of Mark A. Hall)).

4. The crisis of uninsurance also substantially affects interstate commerce in another, related way: It increases the incidence of chronic conditions,

which in turn accounts for the vast majority of the nation's health care expenses.

As discussed at greater length below, *see infra* at 20-21, uninsured Americans are more likely to see health care providers only sporadically and to delay before seeking treatment for illnesses. That leads to a greater incidence of chronic diseases such as diabetes and coronary artery disease, as well as poorer health outcomes for people suffering from those diseases. *See* Institute of Med., *America's Uninsured Crisis: Consequences for Health & Health Care* 2-4 (Feb. 2009). And "[t]he total medical care costs for people with chronic disease account for more than *70 percent* of the nation's health care expenditures"—a massive sum. G. Halvorson, *Health Care Reform Now!* 3 (Wiley & Sons 2007) (emphasis added). That is a "substantial effect" in its own right. And it can only be ameliorated by broad-based coverage, because broad-based coverage gives health care providers the resources and continuity to effectively manage a patient's care over time. The ACA's reforms properly recognize that broader coverage, and integrated care delivery, are crucial to controlling the nation's spiraling health costs.

* * *

In short, the vast cost of health care for the uninsured is borne by the rest of the nation. That cost-shifting badly distorts prices in the health care sector—a sector that accounts for "almost one-fifth of the U.S. economy" and that is nearly as large as the gross domestic product of France. G. Fosler, *Sizing Up the U.S. Health Care Challenge* (July 2011).[12]

[12] *Available at* http://www.gailfosler.com/commentary/chart-of-the-week/sizing-up-the-u-s-health-care-challenge.

That is a quintessential "substantial effect" on interstate commerce. Nothing more is required to uphold the individual mandate as a constitutional exercise of Congress' Commerce Clause power.

B. The Eleventh Circuit's Holding Ignores Facts About the Market And Fails To Defer To Congress's Assessment Of That Market.

The Eleventh Circuit majority held that the crisis of uninsurance lacks a substantial effect on interstate commerce. But it erred twice over in reaching that conclusion: It badly misconstrued the realities of the health care and health insurance markets, and it failed to defer to Congress's understanding of those markets.

1. The Eleventh Circuit stated that "the regulated conduct giving rise to the cost-shifting" in this case "is divorced from a commercial transaction." Pet. App. 133a-134a. It asserted that "[a]t best, we can say that the uninsured *may*, at some point in the *unforeseeable future*, create that cost-shifting consequence." Pet. App. 134a (emphasis in original). And it opined that "the question" in the case was "whether Congress may regulate individuals *outside the stream of commerce*, on the theory that those 'economic and financial decisions' to avoid commerce *themselves* substantially affect interstate commerce." Pet. App. 113a (first emphasis added).

These three assertions drove the court's conclusion that too many "inferential leaps" are required to justify Commerce Clause regulation. Pet. App. 133a. But each one of the assertions is obviously incorrect. The conduct giving rise to the cost-shifting is not "divorced from a commercial transaction"; quite the contrary, that conduct is the consumption of massive

amounts of health care services without the capacity to pay the bill—"commercial" behavior by any definition. And the class of regulated individuals is not "outside the stream of commerce." Instead, they seek health care services frequently and in great numbers, and the value of those services amounts to $86 billion per year. *See supra* at 8. For these reasons, it is indefensible to assert that "[a]t best, we can say that the uninsured *may*, at some point in the *unforeseeable future*, create [a] cost-shifting consequence." Pet. App. 134a. The uninsured most assuredly create a "cost-shifting consequence" in the present—one that distorts the health care and health insurance markets to the tune of hundreds of millions of dollars per day, each and every day of the year. To refuse to recognize as much is either to ignore the facts or to ignore the law, which has long authorized Congress to regulate in the aggregate. *See Raich*, 545 U.S. at 17-19; *Seven-Sky*, 661 F.3d 1, at *19 ("Whether any 'particular person * * * is, or is not, also engaged in interstate commerce' * * * is a mere 'fortuitous circumstance' that has no bearing on Congress's power to regulate an injury to interstate commerce.") (quoting *United States* v. *Wrightwood Dairy Co.*, 315 U.S. 110, 121 (1942)) (first alteration in *Seven-Sky*). Either way it is a fatal flaw in the analysis.

The Eleventh Circuit's attempt to compare this case to the attenuated economic effects present in *Lopez*, Pet. App. 131a-133a, accordingly fails. In *Lopez*, the Court determined that there was an insufficient nexus between the challenged criminal statute and interstate commerce. 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 they cannot afford, and as a result billions of dollars a year in costs are absorbed by third parties, distorting the market. Congress so found, *see* 42 U.S.C. § 18091(a)(2)(F), and its findings were not just rational—they were plainly correct. *See Thomas More*, 651 F.3d at 545. No "inference" is required.

2. In short, the crisis of uninsurance substantially affects interstate commerce, and the link between the two is clear and direct. But of course, the Court need not even accept those propositions to uphold the mandate; instead, all that is required is that "a 'rational basis' exists for so concluding." *Raich*, 545 U.S. at 22. That test is met in spades here. It is obviously rational to conclude, based on the facts just discussed, that the requisite "substantial effect" is present. Nor is the outcome different if the test has more teeth in this context—if, as Justice Kennedy has said, it requires "a demonstrated link in fact, based on empirical demonstration." *United States* v. *Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy,

J., concurring). The evidence set forth above, and recited by Congress in the ACA, amply demonstrates just such a link and relies on empirical evidence to do it. As the Sixth Circuit determined after reviewing that evidence: "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[.]" *Thomas More*, 651 F.3d at 545. Exactly. Whatever the rational-basis test requires in this context, the facts Congress relied upon in enacting the ACA easily clear the bar.

II. THE "ACTIVITY" TEST IS NOT THE LAW, AND IN ANY EVENT IT FAILS ON ITS OWN TERMS.

Every Court of Appeals to reach the question has rejected respondents' attempt to create, and inject into the Commerce Clause analysis, an "activity" requirement. *See* Pet. App. 100a ("[W]e are not persuaded that the formalistic dichotomy of activity and inactivity provides a workable or persuasive enough answer in this case."); *Seven-Sky*, 661 F.3d 1, at *17 (rejecting the argument that "an existing activity is some kind of touchstone or a necessary precursor to Commerce Clause regulation"); *Thomas More*, 651 F.3d at 548 (same). As these courts have correctly recognized, *e.g.*, *Seven-Sky*, 661 F.3d 1, at *17-*18, the proposed "activity" requirement is both unworkable and foreclosed by this Court's precedents. In any event, even if there were an "activity" requirement, it would be met on these facts because uninsured Americans participate in relevant economic activity: They obtain health care services, and they make decisions—by omission or otherwise—about how to fund those purchases.

A. The "Activity" Test Should Be Rejected.

1. This Court has never created or endorsed an "activity" requirement. The Court has used the term only as a descriptor in discussing the broad outlines of Congress's power, *see Lopez*, 514 U.S. at 567 (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.*, *Raich*, 545 U.S. at 17 (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," *Charles C. Steward Machine Co.* v. *Davis*, 301 U.S. 548, 589-590 (1937), because—as the *Seven-Sky* court correctly recognized, 661 F.3d 1, at *17—whether a regulated individual is engaged in relevant activity depends on one's perspective. Almost any individual subject to regulation can be described as "active" or "inactive," depending on the level of generality one adopts. 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. The farmers in *Wickard* v. *Filburn*, 317 U.S. 111 (1942), 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." *Id.* at 129; *see also Seven-Sky*, 661 F.3d 1, at *17. 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.

The mandate's challengers, no doubt, would respond that all of these examples involve some underlying active component—for example, walking to the nuclear facility to start the passive 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. Respondents' argument thus only underscores the fact that whether a regulated individual is sufficiently "active" is a matter of perspective. "[T]he constitutionality of the minimum coverage provision cannot be resolved with a myopic focus on a malleable label." *Thomas More*, 651 F.3d at 548. When such "malleable label[s]" have been created in the past, they have quickly been abandoned as unworkable failures. *See Wickard*, 317 U.S. at 120 ("[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' * * * ."). There is no reason to go down that road again.

B. In Any Event, The Uninsured Participate In Relevant Economic Activity.

Even if "activity" were required to justify Commerce Clause regulation, that requirement would be met here because the uninsured *do* participate in relevant economic activity: They obtain health care services that they cannot afford. Indeed, "virtually everyone" obtains health care services sooner or later, *Seven-Sky*, 661 F.3d 1, at *18, and the cost of providing them to the uninsured is extraordinary. *See supra* at 7-8. 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.

1. Challengers to the mandate argued in the courts below that the uninsured are simply "declining to enter a commercial transaction," and are engaging in no "relevant current economic or commercial activity." Opening Br. of Plaintiffs-Appellants 33, *Seven-Sky*, 661 F.3d 1 (D.C. Cir. 2011) (No. 11-5047), 2011 WL 1877683 ("*Seven-Sky Brief*"). That is inaccurate for the reasons set forth at length above. The uninsured in the aggregate consume $86 billion of health care per year. *See supra* at 8. Much of the cost "is passed on * * * 'to private insurers, which pass on the cost to families.' " *Thomas More*, 651 F.3d at 545 (quoting 42 U.S.C. § 18091(a)(2)(F)). And "[t]his cost-shifting inflates the premiums that families must pay for their health insurance 'by on average over $1,000 a year.' " *Id.*

That is "relevant current economic or commercial activity" by any measure. 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*, 651 F.3d at 544; *see also id.* at 561 (Sutton, J., concurring) ("[I]naction *is* action, sometimes for better, sometimes for worse, when it comes to financial risk.") (emphasis in original). To say the uninsured become "inactive" by declining to purchase insurance is to ignore reality. The uninsured still obtain health care; others just pay for it.

2. Respondents' assertions that they as individuals do not participate in the relevant market are inaccurate for two additional reasons. First, one cannot simply "exit" the health care market. 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. The choice each one of us faces is not whether to participate in the market; it is how to pay for the care we inevitably will receive.

Second, 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 and increases the costs to treat them. 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).[13] 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.*; *see America's Uninsured Crisis*, *supra*, at 2-3 (collecting research findings on poorer outcomes for uninsured patients suffering from various serious diseases).

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).[14] For this reason, too, it makes little sense to suggest that people can declare themselves out of the health care market. Any decision to avoid the health care market in the short term simply

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

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

produces more market activity in the medium and long term. Congress has the authority to recognize as much, and to regulate uninsureds' choices about who will pay for that market activity.

3. In the end, respondents can assert that the uninsured are 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). But that argument, too, fails on its own terms, because the uninsured *are* active in the health insurance market in an important sense: Even those who do not obtain access to that market in a given year are obtaining the free, present benefit of an insurance-funded infrastructure waiting to care for them when they need it. *See Thomas More*, 651 F.3d at 557 (Sutton, J., concurring) ("Congress could reasonably conclude that the decisions and actions of the self-insured substantially affect interstate commerce" because one way to self-insure "is to save nothing and to rely on something else—good fortune or the good graces of others—when the need arises."); U.S. Br. 51.

In any event, the Court should reject respondents' 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 "[i]nsurance is the customary means of payment for services in the health care market." U.S. Br. 2. 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); *see* U.S. Br. 41.

III. THE "SLIPPERY SLOPE" CLAIMS FAIL TO RECOGNIZE THE UNIQUENESS OF THE HEALTH CARE MARKET.

The individual mandate's challengers relied heavily below on slippery-slope arguments, insisting 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." *Seven-Sky Brief* at 32. Congress's assertion of authority in the ACA, they said, 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.* at 39-40, 57.

No. There is a key difference between this case and respondents' hypotheticals: In this case the activity individuals are being "forced" to undertake is a mere financing mechanism for another activity 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. *See Seven-Sky*, 661 F.3d 1, at *18 ("It suffices for this case to recognize" that "the health insurance market is a rather unique one * * * because the uninsured inflict a disproportionate harm on the rest of the market as a result of their later consumption of health care services."). Instead, Congress made sure people pay for what they get. To put things in the challengers' 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).

The alarmist hypotheticals are not just inapposite but unrealistic; they ignore the limits the political process places on Congress's actions. This 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. (9 Wheat.) 1, 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, or sleep at particular times, or any of the rest of the pundits' parade of fantastical hypotheticals, is to abandon all faith in representative democracy.

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 forego 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.

For the foregoing reasons, this Court should uphold the individual mandate.

Respectfully submitted,

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