No. 11-398

IN THE
Supreme Court of the United States

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

Petitioners,

v.

STATE OF FLORIDA, *et al.*,

Respondents.

On Petition for a 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 FEDERAL PETITIONERS

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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] Pursuant to Rule 37.6, counsel certifies that no party, or counsel for a party, authored or paid for this brief in whole or in part, or made a monetary contribution intended to fund its preparation or submission. No person other than *amici*, their members, or their counsel made a monetary contribution to the brief. This brief is filed with the consent of all parties.

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

The National Association of Children's Hospitals 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—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. As part of that mission, they treat tens of millions of uninsured individuals each year, and most of that care is uncompensated. 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

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

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

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"). And it is why this Court should promptly grant the Government's petition for certiorari and hold that the ACA is a constitutional exercise of Congress's Commerce Clause power. The uncertainty that has swirled around the ACA for a year has slowed development of the architecture needed to make the ACA's reforms a reality. The uncertainty should be resolved so that Congress's response to this country's health care crisis can move forward to full implementation.

SUMMARY OF ARGUMENT

1. This Court should grant the Government's petition. The criteria for certiorari review are, of course, met in spades here. *See* E. Gressman, K. Geller, S. Shapiro, T. Bishop, & E. Hartnett, SUPREME COURT PRACTICE 242 (9th ed. 2007) ("Stern & Gressman") (Court regularly grants certiorari to resolve circuit splits); *id.* at 245 (grant is even more likely where issue is "important and recurring"); *id.* at 264 (certiorari usually granted where "the decision below holds a federal statute unconstitutional"). But prompt review is important for two additional reasons. *First*, uncertainty over the ACA's constitutionality impedes beneficial (and non-controversial) elements of the law and slows progress on labor-intensive initiatives like the development of state insurance exchanges. *Second*, it is crucial for the ACA's constitutionality to be reviewed—and reaffirmed. Only then can the crisis of uninsurance, with its rampant

cost-shifting and potentially devastating effects on the uninsured, begin to be addressed.

2. The Court should deny the States' petition to the extent it seeks review of the ACA's Medicaid amendments. The Eleventh Circuit properly applied settled law in rejecting the States' challenge to those amendments. And unlike with the individual mandate, the constitutionality of the Medicaid amendments is not the subject of a circuit split; no federal court has struck them down. The States' petition should be rejected.

ARGUMENT

I. PROMPT REVIEW WILL RESOLVE BUSINESS UNCERTAINTY, ALLOW UNCONTROVERSIAL ACA PROVISIONS TO MOVE FORWARD, AND BEGIN ADDRESSING THE CRISIS OF UNINSURANCE.

This Court should promptly grant the writ because lingering uncertainty over the ACA's constitutionality is adversely affecting the law's implementation and the health care system as a whole.

A. ACA Litigation Uncertainty Is Impeding Implementation Of Even Uncontroversial Parts Of The Law.

1. The cloud hanging over the ACA is impeding even non-controversial, efficiency-promoting provisions of the law from moving forward. For example, the ACA authorizes the Centers for Medicare and Medicaid Services ("CMS") to work with hospitals and other care providers to implement "demonstration projects"—i.e., experimental care delivery and payment models—that are exempt from many CMS regulations. *See*, *e.g.*, 42 U.S.C. § 1315a (describing demonstration projects authorized by the ACA). The

idea is to try innovative solutions to "bend[ ] the Medicare cost curve," improving quality of care and reducing spending. *See New Models for Delivering & Paying for Medicare Services: Hearing before the H. Comm on Ways & Means*, 112 Cong., May 12, 2011.[4] But the demonstration projects generally require substantial commitments of time and money to launch. As a result, hospitals have been reluctant to commit to them while the ACA's future remains up in the air; they simply cannot justify shouldering high start-up costs when the ACA could be struck down, and the demonstration terminated, before any offsetting cost savings could be realized. The uncertainty surrounding the ACA thus dampens hospital participation in a program designed to find solutions to our country's unsustainable Medicare cost spiral.

The litigation uncertainty is creating difficulties for hospitals in other ways too. For example, under the ACA, CMS will make incentive payments to hospitals that meet or exceed certain standards. 42 U.S.C. § 1395ww(o). Conversely, CMS will reduce payments to hospitals with the most "hospital acquired conditions"—i.e., illnesses attributable to a patient's stay in the hospital—and to those with a high percentage of patients who require readmission within a specified time following discharge. *Id.* § 1395ww(p)-(q). These programs are designed to improve patient care through a "carrot-and-stick" approach to hospital reimbursements. *See* Deloitte Center for Health Care Solutions, *Value-based Purchasing: A Strategic Overview for Health Care*

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[4] *Available at* http://waysandmeans.house.gov/News/DocumentSingle.aspx?DocumentID=261534.

Industry Stakeholders 1 (2011).[5] Hospitals must expend—and are already expending—substantial resources to prepare for CMS's implementation of these programs. And yet they recognize that if the ACA is invalidated, these programs may not be able to accomplish their objectives. Only prompt action from this Court can help mitigate that impact.

2. Separately, uncertainty surrounding the ACA has prompted some states to drag their feet in preparing for full implementation. To take just one example: "By January 1, 2014, all states must establish 'American Health Benefit Exchanges' and 'Small Business Health Options Program Exchanges,' which are insurance marketplaces where individuals, families, and small employers can shop for the Act's new insurance products." Pet. App. 32a (citing 42 U.S.C. § 18031(b)). Creating those exchanges is a complex and time-consuming task—and yet many objecting states have not even begun the process, instead "taking a wait-and-see approach and holding off on establishing exchanges until the legal issues are resolved." M. LaPointe, *Health Care Reform in Limbo*, Business NH Magazine (Oct. 5, 2011);[6] *accord* K. Koster, *In the Eye of the Storm*, Employee Benefit Adviser (Mar. 1, 2011) (while some states have begun to design insurance exchanges,

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[5] *Available at* http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/US_CHS_ValueBasedPurchasing_031811.pdf.

[6] *Available at* http://millyardcommunications.com/index.php?src=news&srctype=detail&category=News&refno=2616.

"[o]ther states are cautious and waiting for * * * the judicial challenges to PPACA to be resolved").[7]

That approach, ironically, may produce a degree of health-care federalization that those very states no doubt would decry. "Under the PPACA, the federal government will evaluate each state's progress during 2013. If federal regulators determine that a state exchange will not be implemented by the [2014] deadline, a federally operated exchange will be implemented." *Health Care Reform in Limbo*, *supra*. And "[m]any health policy experts say states are not moving fast enough to set up the exchanges to meet the 2014 deadline." *Id.* As a result, the Department of Health and Human Services has been forced to propose starting a federal exchange on January 1, 2014 and transitioning its functions and enrollees to states one by one through a year-long process as they come into compliance. Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41886, 41871, 41913 (proposed July 15, 2011) (to be codified at 45 C.F.R. pts. 155 and 156). Thus further delay in resolving this case "risk[s] having federally-run exchanges" in greater numbers than would otherwise be necessary, *Health Care Reform in Limbo*, *supra*, needlessly consumes state and federal resources, and needlessly complicates exchange enrollment for the Americans most in need of stable health coverage. *See* Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. at 41871, 41913 (outlining the process for a state exchange to take over the functions of the federal one in that state and noting that the qualified health

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[7] *Available at* http://eba.benefitnews.com/news/eye-storm-2685251-1.html.

plans in the state exchange may differ from the federal one).

B. Review And Reaffirmance Of The ACA's Constitutionality Would Begin The Process Of Alleviating The Crisis Of Uninsurance.

The Court should grant certiorari, and reaffirm the ACA's constitutionality, for a second reason: The ACA's reforms must move forward if the Nation is to address a crisis of uninsurance that will not disappear on its own. Approximately *50 million* American residents, including more than 7 million children, were without health insurance for all of 2010. U.S. Census Bureau, *Income, Poverty, & Health Insurance Coverage in the United States: 2010* at 23-26 (Sept. 2011).[8] The vast majority of these millions of uninsured individuals—at least 94 percent—seek and receive health care services at some point, with the majority obtaining care each year. J.E. O'Neill & D.M. O'Neill, *Who Are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics & Their Health* 20-21 & Tbl. 9 (2009).[9] Indeed, in 2008 alone, those uninsured Americans received some *$86 billion* worth of health care from all providers. *Covering the Uninsured* 399, 402-403.

Those figures are massive and growing. And they come at a steep cost to everyone—the uninsured themselves, hospitals, health systems, insurers, and America's taxpayers. Of the $86 billion in care the uninsured received in 2008, about $56 billion came in the form of uncompensated care provided by

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[8] *Available at* http://www.census.gov/prod/2011pubs/p60-239.pdf.

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

hospitals, doctors, clinics, and health-care systems.[10] Supplemental Medicare and Medicaid payment programs—in other words, American taxpayers—end up footing part of that bill. *Covering The Uninsured* 403-404. State and local governments—taxpayers again—likewise pay a share. *Id.* at 405. And insured patients (and their insurers) end up effectively paying a portion of the bill more directly: As hospitals and other providers absorb costs of uncompensated care, they have fewer funds to reinvest and to cover ongoing expenses, which in turn drives costs higher. *Id.* at 406.

In short, the vast majority of uninsured Americans obtain health care, and most of the steep cost of that care is borne by the rest of the nation. As the Hospital Associations are prepared to explain in detail at the merits stage, these facts doom petitioners' Commerce Clause arguments: Even assuming the coherence of petitioners' activity/inactivity distinction, the uninsured are "active" in both the health *care* market—because they obtain care—and in the health *insurance* market—because 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 Law Center* v. *Obama*, 651 F.3d 529, 557 (6th Cir. 2011) (Sutton, J., concurring) ("Congress could reasonably conclude that the decisions and actions of the self-insured substantially affect interstate commerce" because

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[10] This is derived by subtracting $30 billion in uninsured self-payment from the $86 billion total. *See Covering the Uninsured* 399-403. Of the $56 billion in uncompensated care, the bulk is provided by hospitals, and the rest by doctors, clinics, and other providers. *Id.* at 402-403.

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."). But they are relevant at the petition stage too because they underscore the need to eliminate the uncertainty surrounding the ACA. While the legislation is not perfect, it would extend coverage to millions more Americans and would eliminate costly market distortions. To undo the ACA now would be to maintain an unacceptable status quo.

II. THE COURT SHOULD DENY CERTIORARI WITH RESPECT TO THE ACA'S MEDICAID AMENDMENTS.

The plaintiff States have sought review of several additional questions, chief among them whether the ACA's amendments to Medicaid unconstitutionally "coerce[ ] States into accepting onerous conditions that [Congress] could not impose directly[.]" States' Pet. 1. The Court should decline the States' invitation to review this issue. The Eleventh Circuit applied settled law in rejecting the States' Medicaid argument, and there is no divide between the circuits. Review should be limited to the individual mandate and issues logically intertwined with it.

1. The States argue that "[t]he decision below cannot be reconciled with this Court's precedent concerning the scope of Congress's spending power." States' Pet. 16. But they fail to support that assertion. In the pages that follow, they cite only inapposite dicta from cases such as *New York* v. *United States*, 505 U.S. 144 (1992)—which is not a Spending Clause coercion case at all—and snippets from various court of appeals cases that, by and large, do not support their legal theory. States' Pet. 17-20.

In fact, the Eleventh Circuit's decision rejecting the States' coercion claim is consistent with both *South Dakota* v. *Dole*, 483 U.S. 203 (1987), and with the intermediate appellate decisions that have applied that case. This Court in *Dole* suggested that there could be circumstances in which "the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.' " *Id.* at 211 (quoting *Charles C. Steward Machine Co.* v. *Davis*, 301 U.S. 548, 589-590 (1937)). But it simultaneously recognized that every federal spending statute "'is in some measure a temptation" and that " 'to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties.' " *Id.* (quoting *Steward Mach.*, 301 U.S. at 590). The Courts of Appeals, applying the *Dole* dicta, regularly have held that conditions on Medicaid and other federal grants are not rendered impermissibly coercive just because a significant grant is at stake. *See Jim C. ex rel. J.C.* v. *United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (education grant); *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (Medicaid grant); *Padavan* v. *United States*, 82 F.3d 23, 29 (2d Cir. 1996) (Medicaid grant). Instead, they have recognized that "hard choices do not alone amount to coercion," *Madison* v. *Virginia*, 474 F.3d 118, 128 (4th Cir. 2006), and that putting states to those hard choices does not create the sort of "undue influence" that could cross the line. *Steward Mach.*, 301 U.S. at 590.

The decision below is in accord with those precedents. The panel recognized that "the Medicaid-participating states were warned from the beginning of the Medicaid program that Congress reserved the right to make changes to the program." Pet. App.

60a (citing 42 U.S.C. § 1304). It recognized that "states have the power to tax and raise revenue, and therefore can create and fund programs of their own if they do not like Congress's terms." *Id.* 62a. It observed that "states have plenty of notice * * * to decide whether they will continue to participate in Medicaid by adopting the expansions or not," thus giving them the time to develop replacement programs if they so choose. *Id.* It recognized that Congress has amended Medicaid time and again and that "[n]one of these amendments has been struck down as unduly coercive." *Id.* 61a. And it found that "the federal government will bear nearly all of the costs" associated with the ACA's expansion of Medicaid; as a result, "the idea that states are being coerced into spending money in an ever-growing program" struck the panel as " 'more rhetoric than fact.' " *Id.* 61a-62a (quoting *Dole*, 483 U.S. at 211).

With those considerations in mind, the Eleventh Circuit concluded that "the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act's Medicaid expansion,"[11] and that "[w]here an entity has a real choice, there can be no coercion." Pet. App. 63a. That conclusion is correct under *Dole* and *Steward Ma-*

[11] That conclusion draws support from facts on the ground: Lawmakers in a number of petitioner states have pondered the very move—"dropping out of the federal Medicaid program"—that petitioners assure the Court is impossible. *E.g.*, E. Ramshaw, *Texas Considers Medicaid Withdrawal*, New York Times (Nov. 6, 2010), *available at* http://www.nytimes.com/2010/11/07/us/politics/07ttmedicaid.html?partner=rss&emc=; B. Larrabee, *Florida Might Try to Withdraw from Medicaid*, Florida Times-Union (Feb. 16, 2011), *available at* http://jacksonville.com/news/florida/2011-02-16/story/florida-might-try-withdraw-medicaid.

chine and comfortably in the heartland of the intermediate appellate courts' Spending Clause decisions. *Compare California*, 104 F.3d at 1092 (no coercion despite state's claim that it had "no choice" but to accept Medicaid grant "to prevent a collapse of its medical system").

2. Unable to demonstrate that the Eleventh Circuit's decision is at odds with this Court's precedent, and unable to point to a circuit split on the question whether the ACA's Medicaid amendments are unduly coercive, the States offer several ancillary arguments in support of review. They first hint at a more abstract circuit split, suggesting that the appellate courts are "deeply divided" over the coercion doctrine in general. States' Pet. 17. That purported "deep divide," it turns out, consists merely of various courts' views about whether the judiciary is well-positioned to identify the point when pressure becomes compulsion. *Id.* 17-20. But even the courts suggesting that the judiciary is *not* well-positioned to make that determination would have reached the same outcome—no coercion—as the Eleventh Circuit did here. That does not a circuit split make. As the leading treatise observes: "A genuine conflict, as opposed to a mere conflict in principle, arises when it may be said with confidence that two courts have decided the same legal issue in opposite ways * * * [A]ny effort to mislead the Court into viewing a conflict in principle as a real conflict is almost invariably futile." Stern & Gressman 242.

The States next take issue with the Eleventh Circuit's rationale for rejecting their coercion claim. This approach is a non-starter because it amounts to a claim of "misapplication of a properly stated rule of law"—not normally a ground for certiorari review.

See S. Ct. R. 10(c). But in any event, the States' critiques are unfounded. They say the fact that states have years of advance notice of the ACA's Medicaid changes is irrelevant to the coercion analysis because "notice of a coercive choice does not make it less coercive." States' Pet. 23. Quite the contrary: The Eleventh Circuit observed that when a state has ample notice, that gives it the time to develop its *own* program and abandon the federal version. Pet. App. 62a. It is self-evident that that opportunity increases the degree to which the state has a choice. And choice is the key to the coercion analysis. *See Steward Mach.*, 301 U.S. at 590.

The States also argue that the fact that Congress reserved the right to amend Medicaid is irrelevant to the coercion inquiry because "the States are not arguing that Congress may not make changes to Medicaid. They are arguing that Congress may not *force* changes upon the States by threatening them with the loss of billions of federal dollars." States' Pet. 24. That is nonsensical. Congress has always made compliance with Medicaid changes a condition of continued state participation. *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). Thus *every* "change[ ] to Medicaid" is a "force[d] change," under plaintiffs' view. States' Pet. 24. The distinction they attempt to draw cannot bear weight.

3. Finally, it is important to understand the practical consequences of the doctrine the States advance—consequences that, no doubt, go far towards explaining why no court has accepted their argument. If the States' 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.

As the court below recognized, Pet. App. 60a, 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. Kaiser Comm'n on Medicaid & The Uninsured, *The Medicaid Resource Book* 175 (App'x 1) (2002);[12] *see* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-4999. And 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. Congressional Res. Serv., *How Medicaid Works: Program Basics* 4 (Mar. 16, 2005).[13] Congress presumably enacted these and many similar modifications because it concluded 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.

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

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

This heckler's veto flips the Constitution on its head. *See M'Culloch* v. *Maryland*, 17 U.S. 316, 330 (1819) ("[I]f the law of congress * * * be a constitutional act, it must have its full and complete effects. Its operation cannot be either defeated or impeded by acts of state legislation. To hold otherwise, would be to declare, that congress can only exercise its constitutional powers, subject to the controlling discretion, and under the sufferance, of the state governments."). And it 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 the foregoing reasons, the Government's petition for a writ of certiorari should be granted and the States' petition should be denied in part.

Respectfully submitted,

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October 27, 2011