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

STATE OF FLORIDA, by and through BILL McCOLLUM, *et al.*,	)	
Plaintiffs,	)	
v.	)	Case No. 3:10-cv-00091-RV/EMT
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,	)	
Defendants.	)	

DEFENDANTS' MEMORANDUM IN OPPOSITION
TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The interstate market for health care, representing one-sixth of the American gross domestic product, confronts market failures that threaten the vitality of the entire economy, leave tens of millions of Americans unable to obtain affordable health insurance, and impose on other market participants billions in costs of medical care for the uninsured. In the Patient Protection and Affordable Care Act ("the ACA"), Congress sought to fix these problems. The Act is not an assault on state sovereignty, but rather a response to a national crisis. Since the 1930s, the Supreme Court has repeatedly reaffirmed Congress's authority to address such problems. Plaintiffs are wrong that Congress's constitutional authority is curtailed here because of some undefined and invented "inactivity" label they propose. To begin with, the uninsured are not passive bystanders whom the ACA forces to enter the health care market. As defendants have demonstrated, the substantial majority of the uninsured participate actively in that market, for example, by procuring medical services — for which they often are unable to pay — and by purchasing and dropping health insurance. Even under plaintiffs' novel theory, such individuals would be active and subject to Congress's authority to regulate how they pay for health care. Moreover, even if some of the uninsured were "inactive" under plaintiffs' new standard, plaintiffs cannot show — as they must to sustain their facial challenge to the ACA — that all of the uninsured fall into that category.

In any event, while there are assuredly limitations on Congress's power under the Commerce Clause to address problems affecting even a market as vast and economically important as health care, no court has ever identified plaintiffs' distinction between activity and inactivity as one of them. In particular, no court has held that Congress, in exercising its authority under the Commerce Clause, is entirely disabled from ever requiring individuals to act.

Thus, on multiple grounds, the minimum coverage provision of the ACA does not run afoul of any constitutional limitation. The provision, moreover, is plainly necessary to make this critically important regulation of interstate commerce effective. And because the provision is essential in particular to the ACA's regulation of the conditions that the interstate insurance industry imposes on consumers, to break new legal ground as plaintiffs demand, to take the unprecedented step of striking the provision down, would allow insurers to refuse to cover millions of Americans who have some prior medical problem at the time they seek insurance, leaving them and their families at risk of financially ruinous medical costs. Congress's authority to prevent that outcome is at the heart of its Commerce Clause powers.

The states' challenge to the changes the ACA adopts regarding the cooperative, federal-state Medicaid program is likewise without merit. No court, ever, has held it coercive for Congress to specify conditions on how states can spend money Congress has provided them. This case cannot plausibly be the first. As this Court has already explained, "state participation in Medicaid under the [ACA] is, as it always has been, entirely voluntary." Slip. op. at 51 (Oct. 14, 2010) [Doc. No. 79]. Thus, the ACA does not coerce states to accept the changes it adopts. If a state determines that continued participation in Medicaid is no longer in its interests, it retains "the freedom to opt out of the program." *Id*.

Before addressing these issues, the Court must first ensure that it has jurisdiction to do so. Defendants therefore will first discuss whether plaintiffs have adduced facts necessary to show a case or controversy with respect to the minimum coverage requirement under Article III.

ARGUMENT

I. PLAINTIFFS LACK STANDING TO CHALLENGE THE MINIMUM COVERAGE PROVISION

In their motion to dismiss, defendants challenged the standing of the plaintiffs to challenge the minimum coverage provision that will go into effect beginning in 2014. The Court ruled that the individual plaintiffs, Mary Brown and Kaj Ahlburg, and plaintiff NFIB, insofar as it was suing on behalf of its members, had adequately alleged standing. Slip op. at 30-37.[1]

The Court explained that at the pleading stage, "'mere allegations of injury'" are sufficient to withstand a motion to dismiss based on lack of standing." Slip op. at 30-31 (quoting *Dep't of Commerce v. U.S. House of Representatives*, 525 U.S. 316, 329 (1999)). At the summary judgment stage, however, "the plaintiff can no longer rest on such 'mere allegations,' but must 'set forth' by affidavit or other evidence 'specific facts'" to demonstrate standing. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992) (citing Fed. R. Civ. P. 56(e)).

Plaintiffs' declarations do not meet that burden. The assertion offered in the declarations of Brown, Ahlburg, and various NFIB members to show a present or imminent injury is that "[w]ell in advance of 2014, [declarant] must now investigate whether and how" to obtain insurance. Brown Decl. ¶ 10; Ahlburg Decl. ¶ 9; Grimes Decl. ¶ 10; Klemencic Decl. ¶ 10; McClain Decl. ¶ 10; Thompson Decl. ¶ 10. The quoted language — identical in each of the

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[1] NFIB's standing turns on whether allegations of Brown or other individual members are sufficient. NFIB's allegations that it is spending money to educate members about the Act do not establish standing, *see, e.g.*, *Nat'l Taxpayers Union v. United States*, 68 F.3d 1428, 1433-34 (D.C. Cir. 1995); *Ctr. for Law & Educ. v. Dep't of Educ.*, 396 F.3d 1152, 1161-62 (D.C. Cir. 2005), and this Court's decision on the motion to dismiss did not suggest otherwise.

The Court's ruling on the motion to dismiss likewise did not sustain the states' claim to have standing to challenge the minimum coverage requirement. The states lack such standing. *Massachusetts v. Mellon*, 262 U.S. 447 (1923).

declarations — fudges the issue. It is not clear what qualifies as "well in advance of 2014," or whether it is the same thing as "now."

Ahlburg's declaration, moreover, is internally inconsistent. Ahlburg alleges that he expects to "remain financially capable of fully paying for" his and his family's "healthcare services out of my own resources as needed." Ahlburg Decl. ¶ 4. If so, given the potential cost of medical care, it is not plausible that Ahlburg "must now investigate whether and how to rearrange [his] personal financial affairs so as to ensure the availability of sufficient funds" to pay health insurance premiums or the tax penalty under the ACA for not obtaining insurance in 2014. *Id.* ¶ 9. In any event, having to "investigate" financial arrangements is not an injury sufficient to establish Article III standing.

Brown and the non-party NFIB member-declarants are even more equivocal. Brown does not assert that having to buy insurance for herself will mean (in 2014) that her business will no longer be a "viable going concern," but also cites her need to "investigate" whether that might end up being the case. Brown Decl. ¶ 11. Again, Article III requires a showing of injury, not an asserted need to inquire whether there is one.

Granted, the Court's October 14 Opinion seemed to hold that plaintiffs need not show even future, let alone present, "economic" injury, slip op. at 33, and that it was enough that they will not "want" to buy insurance even if it turns out to be an economic boon, *id*. at 34. Given that law of the case, for present purposes defendants assume *arguendo* that a plaintiff who alleged that she was bound and determined for philosophical reasons not to buy insurance *even if* doing so would be a net financial benefit has shown cognizable "Wallet Injury" rather than the

kind of "Psychic Injury" that ordinarily would not confer standing.[2] But Brown's declaration never says that. It focuses on the economic calculus she would need to investigate.[3] Nor does Ahlburg's declaration take such a stand. He says he does not regard buying insurance as a "sensible or acceptable" use of his money. Ahlburg Decl. ¶ 7. That ambiguous language is consistent with an entirely empirical prediction about the economic utility of his buying insurance, a prediction for which no factual evidence is offered. Such ambiguous, unsupported allegations do not satisfy plaintiffs' burden to establish standing.

* * * * *

As defendants have noted, this case involves issues properly resolved by the elected branches of government, issues that were debated and resolved by those branches, including the legislators appearing in this lawsuit. The very purpose of the case or controversy requirement, including the requisite standing to sue, is to avoid judicial entanglement in such policy disputes. "Determining that a matter before the federal courts is a proper case or controversy under Article III therefore assumes particular importance in ensuring that the Federal Judiciary respects 'the proper — and properly limited — role of the courts in a democratic society.'" *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 341 (2006) (citation omitted). The hedged, ambiguous assertions in plaintiffs' declarations are not sufficient to invoke this Court's jurisdiction or to establish that an Article III Court is the proper forum to resolves the issues presented.

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[2] *See Hein v. Freedom from Religion Found.*, 551 U.S. 587, 618-24 (2007) (Scalia, J., concurring) (criticizing exception to that principle in Establishment Clause cases).

[3] The other NFIB members' declarations suffer from the same problems as Brown's, and indeed use essentially the same language.

II. THE MINIMUM COVERAGE PROVISION IS A VALID EXERCISE OF CONGRESS'S POWER UNDER THE COMMERCE AND NECESSARY AND PROPER CLAUSES

A few simple propositions establish that the minimum coverage provision challenged by plaintiffs is constitutional. The health care market accounts for more than a sixth of the national economy. Mem. in Supp. of Defs' Mot. for Summ. J. ("Defs.' Mem.") 2; ACA §§ 1501(a)(2)(B), 10106(a).[4] A sound market in health insurance is essential to the functioning of that health care market. Failures of that health insurance market resulted in tens of millions of Americans being left without even basic health insurance. Defs.' Mem. 4-5. Congress may regulate that health insurance market under the Commerce Clause. *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944). In the ACA, Congress exercised that authority, in particular by barring insurers from refusing to insure people who have some prior medical condition or from charging people higher premiums based on their medical history. As this Court has recognized, Congress had (at the very least) a rational basis for concluding that the minimum coverage provision is "essential" to those health insurance reforms of the Act. Slip op. at 60. Even plaintiffs acknowledge that the minimum coverage provision they challenge is "concededly indispensable" to those insurance market reforms. Mem. in Supp. of Pls.' Mot. for Summ. J. ("Pls.' Mem.") at 2.[5] From these established premises it follows, under the standard set forth in *Gonzalez v. Raich*, 545 U.S. 1 (2005), and other cases since the 1930s, that the

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[4] Some repetition of of the facts and arguments set forth in defendants' motion for summary judgment is unavoidable in responding to plaintiffs' cross-motion on most of the same issues. However, defendants will seek to minimize that repetition given that the full set of materials submitted by both parties on the overlapping motions will be before the Court as it considers its decision.

[5] Indeed, plaintiffs go even farther and would view the minimum coverage requirement as essential to the entire ACA. *Id.*

minimum coverage provision is within Congress's constitutional authority. *Thomas More Law Ctr. v. Obama*, No. 10-11156, 2010 WL 3952805, at *6-11 (E.D. Mich. Oct. 7, 2010).

Due to a unique combination of features, the health care market is one in which virtually everyone participates, that is, in which everyone is active. Necessarily, in addition to *doing* something when they purchase medical services, people must *do* something to finance their inevitable health care expenditures. Defs.' Mem. 24-29. In the aggregate, these economic decisions regarding how to pay for health care services — including, in particular, decisions to delay or forego coverage and to pay later or, if need be, to depend on someone else to cover the cost of "free" care — substantially affect the interstate health care market, and indeed, the entire U.S. economy. All this conduct by the uninsured — active and regular use of health care services, economic decisions as to how to pay for those services, migration in and out of insurance coverage, and shifting costs to other market participants — is, as Congress found, economic activity. *See* Jack Balkin, *Commerce*, 109 Mich. L. Rev. 1, 46-47 (2010). As the court explained in *Thomas More*:

> The plaintiffs have not opted out of the health care services market because, as living, breathing beings, who do not oppose medical services on religious grounds, they cannot opt out of this market. As inseparable and integral members of the health care services market, plaintiffs have made a choice regarding the method of payment for the services they expect to receive. The government makes the apropos analogy of paying by credit card rather than by check. How participants in the health care services market pay for such services has a documented impact on interstate commerce. Obviously, this market reality forms the rational basis for Congressional action designed to reduce the number of uninsureds.

2010 WL 3952805, at *9.

To advance their contrary argument that some significant number of people are "inactive" and therefore, in plaintiffs' view, immune from regulation, plaintiffs dispute that the health care market place is "unique." Pls.' Mem. 14. To be sure, plaintiffs seem to concede that

health care is a necessity.[6] They argue, however, that with equal "inevitability," everyone will need food, clothing, and housing. *Id*. at 10-11. But this misses the point that it is a "unique *combination* of features," Defs.' Mem. 33 (emphasis added), that characterizes the health care market. We need daily bread, but not a daily emergency room visit. Health care is not just a necessity, but a necessity for which one's need can be variable, unpredictable, and catastrophically expensive. One might have a streak of 2,130 consecutive days with $0 in health care bills, only to incur huge bills beginning the 2,131st. Moreover, compared to food, clothing, or shelter, one can do relatively little to adjust one's consumption of health care to one's income. A person of modest means can choose not to buy an expensive house, expensive clothes, or expensive meals. He cannot choose to be invulnerable to an expensive disease or a serious accident. As a result, insurance does not play the same central role in other necessity markets. And the lack of insurance does not result in others bearing the costs incurred by the uninsured. In sum, the health care market is "unlike other markets." *Thomas More*, 2010 WL 3952805, at *9; *see also* Br. of Economic Scholars as *Amici Curiae* 13-15 [Doc. No. 125] (the minimum coverage provision "is tailored to address a unique market imperfection arising from characteristics that do not exist in other markets").

Thus, the parade of horribles plaintiffs predict if the minimum coverage provision is sustained is a product of imagination, not logic. The laws plaintiffs hypothesize (Pls.' Mem. 14-15 & n.14) bear no resemblance to the individual responsibility requirement Congress found essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be

[6] Plaintiffs do note, however, that Americans may "refuse healthcare services." Pls.' Mem. 11. But while some people, perhaps most people at some point or other, refuse *some* health care services, few refuse *all* health care services, and no one who does is a plaintiff here.

sold. And the analogies plaintiffs proffer from other markets lack one or more of the characteristics that stem from the unique features of the health care market. Because the combination of circumstance and market structure that led Congress to enact the individual responsibility provision does not occur in any other market, a decision upholding the minimum coverage provision would not validate the imagined extensions of regulatory authority in other areas. The congressional response here to problems in a market in which virtually all are already participants and are already entitled by law to receive medical services can be sustained without implying that Congress can compel Americans to enter into other markets in which they do not already, and may never, participate.

Moreover, plaintiffs' proposed activity-inactivity distinction breaks down in practice. Is someone active when they purchase medical services? Plaintiffs have conceded that they are. Hr'g Tr. 62-63 (Sept. 14, 2010). When they schedule their appointment with the doctor? After the appointment? If an individual who currently has an insurance policy is engaged in economic activity and can be regulated, under plaintiffs' theory, does congressional power evaporate the day he drops his policy? The day after? The week, month, or year after? These are not the types of questions or distinctions on which constitutional powers should turn, yet they would flow inevitably from plaintiffs' novel theory. These questions also illustrate how plaintiffs' theory could not possibly show that the minimum coverage requirement would be invalid *on its face*. Even if the provision were invalid as to those who are, at least under plaintiffs' theory, "inactive," it would still be valid as to those who are active in the health care market. And, given plaintiffs' concession at oral argument that those who get health care are active (no plaintiff claims to fall within the small group that is not active) and the reality that the majority of people have health insurance and, by plaintiffs' definition, are therefore active in the health insurance

market, the Act is, even under plaintiffs' theory, clearly valid as to all but a very small and unidentified group. Plaintiffs have thus failed to carry their burden of showing that "no set of circumstances exist under which the Act would be valid." *United States v. Salerno*, 481 U.S. 739, 745 (1987).

Even if one granted plaintiffs' premise that those who decide to let someone else pay for their health care are "inactive," plaintiffs' conclusion that, by dint of such "*failure*," Pls.' Mem. 5, (emphasis original), those inactive citizens would be *categorically* immune from any congressional regulation under the commerce power, simply does not follow. Relying heavily on *New York v. United States*, 505 U.S. 144 (1992), and *Printz v. United States*, 521 U.S. 898 (1997), plaintiffs contend that allowing Congress to compel individual citizens to act would be inconsistent with the states' status as "dual sovereigns." According to plaintiffs' argument, *New York* and *Printz* hold that the federal government may not commandeer the *states*, may not compel them to act. From this, plaintiffs seem to reason that the federal government must likewise be forbidden from compelling citizens to act, for if the federal government could do an end run around its inability to command the states by instead commanding the states' citizens directly, that would equally deprive the states of their roles as dual sovereigns. Pls.' Mem. 20-23.

Plaintiffs' argument turns *New York*, *Printz*, and the Constitution on their heads. The United States is also a sovereign. *New York* and *Printz* hold that Congress cannot directly command the states *because* the Constitution "'established a more perfect union by substituting a national government, acting, with ample power, *directly upon the citizens*, instead of the Confederate government, which acted with powers, greatly restricted, only upon the States.'" *New York*, 505 U.S. at 162 (quoting *Lane County v. Oregon*, 74 U.S. 71, 76 (1869)). "[T]he Framers explicitly chose a Constitution that confers upon Congress the power to regulate

individuals, not States." *New York*, 505 U.S. at 166; *accord Printz*, 521 U.S. at 919-21.

Congress's objective in exercising this power — reining in practices by the interstate insurance industry that injure consumers across the nation and resolving a crisis in the vast interstate healthcare market — is clearly within the ambit of the legitimate objectives authorized by the Commerce Clause. Simply stated, the Commerce Clause empowers Congress to regulate in order to achieve these goals. Where, as here, the end is appropriate, the Court has made clear that Congress need only have a rational basis for its choice of means. That test reflects judicial deference to Congress's selection of appropriate means both because that selection is a constitutional prerogative of a coordinate, democratically elected branch of government, and because Congress has superior institutional capacity to choose those means. *United States v. Comstock*, 130 S. Ct. 1949, 1957 (2010). That deference, however, does not accord Congress limitless authority. The requirement that the means Congress selects be "necessary and proper" to the exercise of an enumerated Congressional power is inherently a limitation. Moreover, any federal law is subject to the limitations on governmental power imposed under the Bill of Rights, including the Tenth Amendment bar on commandeering state officials and resources. But within those limits, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses *every power* needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *Wrightwood Dairy Co.*, 315 U.S. at 118-19) (emphasis added). Thus, in pursuing its legitimate objectives of banning harmful practices in the interstate insurance industry and ameliorating the crisis in the interstate healthcare market, Congress was entitled to choose means that included requiring citizens to take some action to ensure that health care services will be paid for by consumers, that such services will be available and affordable, and that insurance as a viable means of financing health care services will continue to exist.

There is nothing extraordinary about this authority. In the exercise of other enumerated powers, Congress has required people to act, and the Court has validated those exercises of authority. Indeed, the First and Second Congresses, which included many of the Framers of the Constitution, enacted statutes exercising the national sovereign's power to require citizens, including those who were otherwise inactive, to act.[7] There is no Commerce Clause exception to that sovereign authority. The commerce power, "like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." *Gibbons v. Ogden*, 22 U.S. 1, 196 (1824). Thus, for example, in the *Gold Clause Cases* the Supreme Court sustained the congressional exercise of the commerce power to require persons holding gold bullion, coin, or certificates to exchange them for paper currency. *See Nortz v. United States*, 294 U.S. 317, 328 (1935); *see also Norman v. Balt. & Ohio R.R. Co.*, 294 U.S. 240, 296, 303 (1935) (recognizing requirement as exercise of commerce power); *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258-59 (1964) (Commerce Clause reaches decisions not to engage in transactions with persons with whom plaintiff did not wish to deal).[8]

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[7] Judiciary Act of 1789, ch. 20, §§ 27, 29-30, 1 Stat. 73, 87-90 (requirements to serve in posse, as juror, or as witness); An Act Providing for Enumeration of the Inhabitants of the United States, ch. 2, § 6, 1 Stat. 101, 103 (1790) (obligation to give account to census takers); Second Militia Act of 1792, ch. 38, § 1, 1 Stat. 264, 265 (requiring men to obtain firearms, ammunition, and related equipment).

[8] Plaintiffs argue that it raises some "presumption" against the minimum coverage provision that, if one describes the provision with enough particularity, a prior statute sharing every one of its features could not be found. Pls.' Mem. 12. This results in part from the very uniqueness of the health care market that plaintiffs deny and in part from the deliberateness with which our system of checks and balances has arrived at this solution. The states' own description of *their* power to impose what they call "individual mandates" shows how rarely such mandates are imposed by the states, yet the states freely claim to have such relatively rarely exercised power. So too, where the federal government's power is concerned: "It is true, this power of the Federal government has not heretofore been exercised adversely; but the non-user

Granted, the *sphere* to which the Commerce Clause extends should not be expanded to "embrace effects upon interstate commerce so indirect and remote that to embrace them, in view of our complex society, would effectually obliterate the distinction between what is national and what is local." *NLRB v. Jones & Laughlin Steel Co.*, 301 U.S. 1, 37 (1937). In particular, the Court has not allowed the Commerce Clause to extend to local, non-economic activity that has only remote and theoretical effects on interstate commerce. *E.g.*, *United States v. Lopez*, 514 U.S. 549, 567 (1995). Those are the terms of the Court's analysis in Commerce Clause cases — whether the regulation targets national, as opposed to purely local matters, whether the regulated conduct is economic or noneconomic, and whether there is a proximate or an attenuated connection to interstate commerce. Plaintiffs' proposed inactivity-activity distinction appears nowhere in the Court's analysis and is irrelevant to the concerns the Court addressed. Plaintiffs' proposed limitation would be particularly perverse in cases like this one where Congress is attempting to remedy direct and proximate effects on an interstate market comprising more than a sixth of the *national* economy. In addressing the inability of millions of Americans to obtain health insurance, the "job lock" that clogs the interstate labor market when employees avoid changing employment because they fear losing health insurance, the costs of providing health care to the uninsured that are shifted to others throughout the country, Congress plainly dealt with issues that are economic, national, and of a magnitude precluding legitimate dispute regarding their substantial effects on interstate commerce.

Plaintiffs also argue that the minimum coverage provision cannot be a necessary "means" to make a regulation of commerce effective, because it is not a "means" at all, but the "end" of

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of a power does not disprove its existence." *Kohl v. United States*, 91 U.S. 367, 373 (1875) (discussing eminent domain power).

universal coverage. Pls.' Mem. 17-18, 19. Plaintiffs cannot substitute their own conception of the objective of the ACA for the one articulated by Congress. Congress identified the minimum coverage provision not as an end in itself, but rather as "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." ACA § 1501(a)(2)(I). Insofar as the provision serves the end of universal coverage, the findings made clear that it does so "by building upon and strengthening the private employer-based health insurance system." *Id.* § 1501(a)(2)(D). Nowhere does Congress suggest that the minimum coverage provision is, as plaintiffs suggest, of itself the alpha and omega of the ACA.

Moreover, there is no rule that a means to achieve a statutory goal cannot in some respects also be an end. To whatever extent requiring some citizens to obtain coverage that they claim they will not want secures the "end" of covering those citizens, it is *also* a means of protecting other citizens in the market, of assuring that millions of others who do want coverage can obtain it.[9] No more is required.

Plaintiffs' effort to require more rests on a misreading of *United States v. Comstock*, 130 S. Ct. 1949 (2010), and a misapplication of *Comstock* to the circumstances of this case. Ignoring the standard the Court actually applied in *Comstock*, plaintiffs would fashion a new standard under the Necessary and Proper Clause from the Court's discussion of why the result of the existing test was particularly appropriate with regard to the particular statute at issue there, even

[9] An example of a provision that was both means and end is provided by the plaintiffs' brief, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), which upheld compulsory vaccination under a state law. Pls.' Mem. 16. If protecting everyone from smallpox was the "end," then, insofar as vaccinating Mr. Jacobson protected Jacobson himself, it was, in plaintiffs' terms, serving the "end" of universal protection. But that did not prevent it from *also* being a "means" to protect everyone else. 197 U.S. at 31-32.

though it extended federal authority farther than in this case. Pls.' Mem. 18-20. In fact, *Comstock* reiterated the "breadth" of the Necessary and Proper Clause, reciting the long line of cases since *M'Culloch v. Maryland*, 17 U.S. (4 Wheat) 316 (1819), establishing that Congress gets to choose how to implement its enumerated powers, so long as its choices have a rational basis. *See Comstock*, 130 S. Ct. at 1957. The Eleventh Circuit has so understood *Comstock*. *United States v. Belfast*, 611 F.3d 783, 804-05 (11th Cir. 2010).

Even if, contrary to *Belfast*, *Comstock* — without saying so — displaced the rational basis test with some new multi-factoral balancing, plaintiffs strike the wrong balance here. Plaintiffs suppose there to be no "long 'history of involvement'" by the federal government in the area of regulation in this case comparable to that in *Comstock*, Pls.' Mem. 18, yet the federal government has regulated the field of health insurance for decades, *see* Defs.' Mem. 17-18 & n.6, indeed, for the entire period the national health care and health insurance markets have existed in their current form.[10] Plaintiffs also argue that the ACA "does not 'properly account[] for State interests,' as did the law upheld in *Comstock*," Pls.' Mem. 19, given that, according to plaintiffs, the law exercises "power that the Constitution reserves to the States," *id*. at 20. However, as *Comstock* itself makes clear, "[t]he powers 'delegated to the United States by the Constitution' include those specifically enumerated powers listed in Article I along with the implementation authority granted by the Necessary and Proper Clause. Virtually by definition, these powers are not powers that the Constitution 'reserved to the States.'" 130 S. Ct. at 1962 (quoting U.S. Const. amend. X). If, like the minimum coverage provision, a measure is rationally related to the implementation of other enumerated powers, it is valid under the

[10] *See, e.g.*, Paul Starr, *The Social Transformation of American Medicine* 320-27 (1982) (describing growth of national commercial health insurance market after World War II).

Necessary and Proper Clause, and the Tenth Amendment is not implicated at all.[11]

Plaintiffs' argument boils down to an undocumented contention that this case is unprecedented, that no court has ever upheld a regulation of inactivity, and that the ACA is therefore presumptively unconstitutional. Plaintiffs' premise is not only incorrect, but irrelevant, and the conclusion they wrongly extract from it would invert the longstanding and overriding presumption, fundamental to our democratic system, that the laws enacted by Congress are constitutional, *United States v. Comstock*, 130 S. Ct. 1949, 1957 (2010) (quoting *United States v. Morrison*, 529 U.S. 598, 607 (2000)). The appropriate — and accurate — point is that where, as here, Congress's objective falls within the Commerce Clause, no case in the modern era has struck down a provision on the ground that the means Congress chose to achieve that end, though not barred by any provision of the Bill of Rights, nonetheless exceeded Congress's power over interstate commerce. It is thus plaintiffs who stake out an unprecedented position in enlisting the Judiciary in their effort to invalidate legislation that they opposed, and continue to oppose, in the legislative arena.

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[11] Moreover, the ACA also accounts for the states' interests by permitting a state to apply to waive the operation of certain of the ACA's provisions, including the minimum coverage provision, within its borders if the state can establish that an alternative plan would meet certain criteria. ACA § 1332. Other provisions of the ACA take into account the states' interests as well. For example, states will be eligible for a substantial portion of billions of dollars in the ACA's Prevention and Public Health Fund. *See* ACA § 4002. This $15 billion in funding over 10 years will help bolster states' health care workforces, create jobs in state and local health departments, and support effective prevention and public health programs in states. And one study found that the increased Community Health Center funding in the ACA could lead to $33 billion in State Medicaid savings between 2010 and 2019. *See* Leighton Ku et al., George Washington University's Geiger Gibson/RCHN Community Health Foundation Research Collaborative, *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform* (June 30, 2010), *available at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_895A7FC0-5056-9D20-3DDB8A6567031078.pdf (last visited Nov. 22, 2010).

Accordingly, for the reasons stated above and in the memorandum supporting defendants' motion for summary judgment, the Court should uphold the minimum coverage provision as a valid exercise of Congress's powers under the Commerce and Necessary and Proper Clauses.

III. THE AMENDMENTS TO MEDICAID FALL WITHIN THE SPENDING POWER

Plaintiffs' claim that the Act's amendments to the Medicaid program are unconstitutionally coercive rests on three flawed premises: (1) that the Act "transforms" Medicaid in impermissible and unforeseeable ways; (2) that states' participation in Medicaid is not voluntary because no legal mechanism permits them to exercise their right to opt out; and (3) that states have "no choice" but to accede to the amendments, despite their difficult budget situations, because of the size or importance of federal Medicaid grants. Each of these contentions is demonstrably wrong, if not legally irrelevant, as shown below.

A. Nine of the Twenty Plaintiff States Lack Standing To Pursue Their "Coercion" Claims

"[T]he standing inquiry requires careful judicial examination . . . to ascertain whether the *particular plaintiff* is entitled to an adjudication of the *particular claims* asserted." *Allen v. Wright*, 468 U.S. 737, 752 (1984) (emphasis added). And because the core requirements of Article III standing — injury in fact, causation, and redressability — are "an indispensable part of the plaintiff's case, each . . . must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, *i.e.*, with the manner and degree of evidence required at the successive stages of the litigation." *Lujan*, 504 U.S. at 561. At summary judgment, a "plaintiff can no longer rest on . . . 'mere allegations,' but must 'set forth' by affidavit or other evidence 'specific facts'" establishing his standing. *Id.*

Here, nine of the twenty plaintiff states — Alabama, Alaska, Colorado, Idaho, Michigan, Mississippi, Pennsylvania, South Carolina, and Washington — submit no evidence of the allegedly coercive effect of the federal Medicaid grant at stake. Thus, they fail to establish that any alleged injury is caused by the ACA's Medicaid amendments, rather than their voluntary choice to participate in the Medicaid program. *See Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 831 (D.C. Cir. 2006) (self-inflicted harm cannot constitute a cognizable injury); *cf. Padavan v. United States*, 82 F.3d 23, 29 (2d Cir. 1996) (adherence to spending conditions required "only . . . because [the] State participates in the federal Medicaid program," a choice that is "voluntary"). Accordingly, they fail to establish standing, and their motion for summary judgment on Count Four must be denied. *See id.*[12]

B. The Affordable Care Act Does Not "Transform" Medicaid

Plaintiffs have never disputed that, under the Spending Clause, Congress may "fix the terms on which it shall disburse federal money to the States," *New York v. United States*, 505 U.S. 144, 158 (1992), and may "condition[] receipt of federal moneys upon compliance . . . with federal statutory and administrative directives," *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). Provided the four *Dole* factors are met, it is fully within Congress's spending power to alter the terms of a federal spending program, whether those changes are fundamental or merely minor — just as it is the states' prerogative to decline federal funds attached to conditions they dislike. Thus, as an initial matter, even if the states were correct that the ACA fundamentally "transforms" Medicaid, that is irrelevant to the Spending Clause analysis. As the Eleventh

[12] The same is true for the other plaintiff states, of course, because the decision whether to participate in Medicaid remains voluntary regardless of the size or importance of the federal Medicaid grant at stake. However, for those states, the standing inquiry effectively collapses with the coercion inquiry.

Circuit has explained, "there is no standard of proportionality for spending legislation. . . . If a State wishes to receive any federal funding, it must accept the related, unambiguous conditions in their entirety." *Benning v. Georgia*, 391 F.3d 1299, 1308 (11th Cir. 2004) (citation omitted); *see also Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998) (a "recipient of federal funds under Spending Clause legislation always retains th[e] option" of "terminating [the] receipt of federal money rather than assuming unanticipated burdens") (citation omitted).

In any event, the notion that the ACA "transforms" or "revolutionizes" the Medicaid program, Pls.' Mem. 26, 38, is pure hyperbole. As this Court has recognized, Congress "expressly reserved the right to alter or amend the [Medicaid] program," slip op. at 51 (citing 42 U.S.C. § 1304), and, "in fact, . . . has done so numerous times over the years," *id.* — in particular, to expand eligibility, *see* 42 U.S.C. § 1396a note. And it has always been *Congress* that has defined the core groups to be covered and services to be offered, while giving states the option to exceed these baseline requirements (and thus obtain additional federal matching funds). For example, Congress has required states to extend Medicaid eligibility to recipients of Supplemental Security Income, *see* Pub. L. No. 92-603 (1972), and to pregnant women and children under age six, *see* Pub. L. No. 101-239 (1989). *See also* Br. of Am. Acad. of Pediatrics et al. as *Amici Curiae* 5-14 [Doc. No. 134] (chronicling Medicaid amendments from 1965 to present). Through these and other amendments, between 1966 and 2000, Medicaid enrollment expanded from 4 million to 33 million. John Klemm, Ph.D., *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105, 106 (Fall 2000). The ACA leaves this core Medicaid framework intact. Its key change — the expansion of eligibility to childless adults below 133 percent of the federal poverty level — is analytically indistinguishable from prior expansions.

Plaintiffs' argument that this expansion is a forbidden "transformation" rests on one principal contention: that in *Harris v. McRae*, 448 U.S. 297 (1980), the Supreme Court noted that Medicaid was originally intended to assist "'*needy persons*,'" Pls.' Mem. 26 (quoting *McRae*, 448 U.S. at 308), while the ACA supposedly goes beyond that point, requiring states to offer coverage to some individuals "*above* the federal poverty line," *id.* That argument is spurious.

To begin, nothing in *McRae* ties eligibility for Medicaid to the federal poverty line, and plaintiffs cite no support for such an arbitrary principle. *See* Pls.' Mem. 26. In any event, the suggestion runs counter to history, practice, and common sense. First, the Medicaid Act has long required participating states to offer coverage to some groups above the poverty level, such as pregnant women and young children. 42 U.S.C. § 1396a(a)(10)(A)(i)(IV), (VI). Second, before the ACA, many states already opted to provide Medicaid assistance to some childless adults above the poverty level through optional eligibility categories or demonstration projects — including plaintiffs Indiana, Idaho, and Utah.[13] Third, the Medicaid Act specifically provides for assistance to those "whose income and resources are insufficient" to meet the costs of medical care. 42 U.S.C. § 1396d(a). Those with incomes between 100 and 133 percent of the federal poverty level make just $10,830 to $14,404 per year, *see* 75 Fed. Reg. 45628, 45629 (Aug. 3, 2010), which is insufficient to manage the $4,530 average annual cost of health insurance (premiums and out-of-pocket costs) in the individual market. *See* Kaiser Family

[13] *See also, e.g.*, Pls.' Mem. Ex. 1 ¶ 26 (Florida already covers, at its option, pregnant women up to 185 percent FPL; women with breast and cervical cancer up to 200 percent FPL; and persons in need of long term care up to 222 percent of FPL); Ex. 9 ¶ B.1 (Arizona already covers, at its option, 200,000 childless adults and certain institutionalized persons up to 300 percent FPL); Ex. 12 ¶ B.1 (Louisiana already covers, at its option, 102,000 childless adults and certain institutionalized persons up to 300 percent FPL).

Foundation, *Survey of People Who Purchase Their Own Insurance* 4 (June 2010), *available at* http://www.kff.org/kaiserpolls/upload/8077-R.pdf.[14] There is nothing magic about the federal poverty line, and *McRae* does not suggest otherwise.

If anything, *McRae* undermines plaintiffs' coercion claim. There, the Court addressed a narrow statutory question: whether the Medicaid Act requires a state to bear the full cost of abortion procedures where the Hyde Amendment bars the use of federal Medicaid matching funds for reimbursement. *Id.* at 301. Based on the language and legislative history of the Medicaid Act and the Hyde Amendment, the Court answered no. *Id.* at 309. Its reasoning underscores the flaws in plaintiffs' argument. Plaintiffs argue that the Court expressed "concern" that Congress might undermine the "Medicaid partnership model" by imposing the full cost of services on states. Pls.' Mem. 26 (citing *McRae*, 448 U.S. at 309). But the Court cited Medicaid's "basic structure" of "federal and state cooperation," *McRae*, 448 U.S. at 309 n.12, as evidence that Congress had not *intended* the Hyde Amendment to shift the full costs of abortion procedures to the states. It articulated no *constitutional mandate* to freeze the contours of the program as they stood in 1980. To the contrary, immediately after noting that Medicaid

[14] Plaintiffs lack standing to challenge ACA § 2304. That section modifies the definition of "medical assistance" in 42 U.S.C. § 1396d(a) by adding the following italicized text: "The term 'medical assistance' means payment of part or all of the cost of [certain] care and services *or the care and services themselves, or both*." Plaintiffs, on the one hand, characterize this amendment as imposing a new "require[ment] that States (but not the federal government) assume the responsibility of *providing* medical care" and speculate that it "surely will engender litigation against Plaintiff States." Pls.' Mem. 26, 42 n.42. But on the other, they concede that the amendment is "unclear in its import and effect, and thus not amenable to cost projections." *Id.* at 42 n.42. Several plaintiff states reinforce this concession in their declarations. *See, e.g.*, Pls.' Mem. Ex. 16 at 2 ¶ 4, 4 ¶ 6 (Nevada) (impact "unclear" and "cannot be assessed until regulations are promulgated" by CMS); *id.* Ex. 18 ¶ 12 (South Dakota) (change "may . . . alter South Dakota's Medicaid program" but CMS "has provided no guidance on whether or how"). Such indistinct, conjectural injuries fail the basic requirements of Article III standing, *see Lujan*, 504 U.S. at 560, and alternatively, are not ripe for review, *see Abbott Laboratories v. Gardner*, 387 U.S. 136, 148-49 (1967).

was not "*designed* . . . as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund," the Court, in a statement that plaintiffs ignore, rejected the point they advance here: "This is not to say that Congress may not now depart from the original design of [Medicaid] under which the Federal Government shares the financial responsibility for expenses incurred under an approved Medicaid plan." *Id.* at 309. Indeed, the Court went on to note that "subsequent Congresses *have* deviated from the original structure of [Medicaid] by obligating a participating State to assume the full costs of a service as a prerequisite for continued federal funding of other services." *Id.* at 309 & n.13 (emphasis added).

In the ACA, not only did Congress refrain from imposing on participating states the full costs of new Medicaid services (subject to the states' right to withdraw), it in fact substantially *increased* federal funding — to 100 percent of expenditures for newly eligible recipients through 2016, gradually declining to 90 percent in 2020 and beyond, far above the usual federal matching rates. ACA § 2001(a)(3)(B); HCERA § 1201.

In any event, given the evolution of Medicaid since 1965, plaintiffs' suggestion that further amendments were unforeseeable, Pls.' Mem. 36-37, would be implausible even if Congress had not expressly reserved the "right to alter, amend, or repeal any provision" of the Act. 42 U.S.C. § 1304. Indeed, the Supreme Court has explained that, with this "language of reservation," Congress "has given special notice of its intention to retain[] full and complete power to make such alterations and amendments as come within the just scope of legislative power." *Bowen v. POSSE*, 477 U.S. 41, 53 (1986) (citation omitted). In *POSSE*, the Supreme Court rejected a quasi-contractual argument far stronger than plaintiffs' claim here. In 1983, Congress amended the Social Security Act to bar states from withdrawing their employees from

Social Security, even though the states had voluntarily entered the system by executing agreements that expressly allowed termination at their option. *Id.* at 45. The amendment negated this option, even as to withdrawals already in process. Nonetheless, the Supreme Court rejected a challenge brought by public agencies of California. *Id.* at 49-50. The Court reasoned that 42 U.S.C. § 1304 "expressly notified the State that Congress retained the power to amend the law under which the Agreement was executed and by amending that law to alter the Agreement itself." *Id.* at 54. *POSSE* thus establishes that states enter Medicaid subject to, and on notice of, Congress's authority to amend the program. Indeed, the ACA is, if anything, *less* intrusive on state prerogatives than the law upheld in *POSSE*, as the ACA's amendments do not revoke a state's option to withdraw from Medicaid if it concludes that participation is no longer advantageous.

Viewed in context, then, the ACA is far from "revolutionary": It builds on the existing Medicaid framework, expanding eligibility but leaving the program's core structure unchanged. In fact, by *increasing* the federal matching rate for the newly eligible and *preserving* states' ability to opt out of the program, Congress stopped well short of exercising the much broader powers that the Supreme Court acknowledged were available to it in *McRae* and *POSSE*.

C. Under the ACA, Medicaid Remains Entirely Voluntary and There Is No Procedural Obstacle to Withdrawal

Plaintiffs are wrong to insist that there is no way for a state to exit the Medicaid program if it determines that participation is no longer in its interests. Pls.' Mem. 34-36. This Court has recognized the "simple and unassailable fact" that "state participation in Medicaid under the [ACA] is, as it always has been, entirely voluntary." Slip op. at 51. Thus, a state that wishes to end its participation retains "the freedom to opt out of the program." *Id.* In arguing otherwise,

plaintiffs attempt to swim upstream against a wealth of Supreme Court and Eleventh Circuit precedent. *See, e.g.*, *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Fla. Ass'n of Rehab. Facilities v. Fla. Dep't of Health & Rehab. Servs.*, 225 F.3d 1208, 1211 (11th Cir. Fla. 2000) ("No state is obligated to participate in the Medicaid program.").[15]

As defendants previously explained, one way for a state to end its participation in Medicaid is to submit a proposed state plan amendment to that effect. *See* Reply in Supp. of Defs.' Mot. to Dism. 5 n.2 (citing 42 C.F.R. § 430.12). This mechanism could provide for a more orderly transition out of the program, with continued federal funding for the eligible population while the state prepares for termination and develops alternative options for individual beneficiaries. During that period, if the state continues to receive federal matching payments, it would be expected to comply with the Medicaid Act's standard statutory and regulatory requirements, such as providing sufficient notice to Medicaid enrollees who would lose coverage, *see* 42 C.F.R. § 435.919.[16] A state seeking a more orderly transition could also propose a demonstration project, under which some standard Medicaid requirements may be waived and continued federal funding may be available, at the Secretary's discretion, if the project will serve the goals of the Medicaid program. *See* 42 U.S.C. § 1315(a). However, a state could — at its option — decide to end its participation more abruptly. A state could simply

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[15] Even if technically dicta, the Supreme Court's statements on this point are entitled to "considerable weight." *United States v. Rozier*, 598 F.3d 768, 771 n.6 (11th Cir. 2010); *Peterson v. BMI Refractories*, 124 F.3d 1386, 1392 n.4 (11th Cir. 1997) ("[D]icta from the Supreme Court is not something to be lightly cast aside.").

[16] Plaintiffs are mistaken that, under this scenario, they "first would have to give . . . a fair hearing to current beneficiaries, who number in the millions." Pls.' Mem. 35 n.33. If a state enacts a law ending its participation in Medicaid, no such hearings would be required. 42 C.F.R. § 431.220(b) ("The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients.").

withdraw its state plan and cease claiming federal matching payments. *See* 42 U.S.C. § 1396b(a) (federal funding available only where state plan is in effect). Or if a state notified the Secretary that it would no longer comply with any of the requirements of the Medicaid Act, 42 U.S.C. 1396a, the Secretary could terminate federal funding, *id.* § 1396c. But plaintiffs' suggestion that a state's withdrawal from Medicaid would necessarily be abrupt or harmful to current enrollees, *see* Pls.' Mem. 35-36 & n.34, ignores the discretion the Medicaid Act affords the Secretary to deal with such issues in a termination. *See, e.g.*, *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 291-94 (4th Cir. 2002) (under 42 U.S.C. § 1396c, the Secretary has discretion to withhold only part of a state's Medicaid funds for noncompliance).

The evidence here demonstrates that the plaintiff states are well aware that there is no procedural obstacle to their opting out of Medicaid. Earlier this year, in the analogous CHIP program, plaintiff Arizona submitted (but later withdrew) a letter terminating its participation in CHIP, which it asked to be treated as a state plan amendment. Pls.' Mem. Ex. 33. Two plaintiff states — Nevada and South Dakota — concede in their declarations that they can, in fact, opt out of Medicaid. *See* Pls.' Mem. Ex. 16 at 7 ¶ 2 (Nevada) ("[T]he Act does not revise provisions of the Social Security Act that . . . provide the option for the State to participate in the Medicaid program" and, thus, "Nevada can still consider opting out of Medicaid a viable option."); *id.* Ex. 18 ¶ 16 (South Dakota) (withdrawal is "theoretically possible"). And government officials in some plaintiff states, including Texas and Washington, have publicly indicated that they are considering opting out.[17] Contrary to plaintiffs' contention that the states lack any "*real* choice,"

[17] Emily Ramshaw, *Texas Considers Medicaid Withdrawal*, N.Y. Times, Nov. 6, 2010, at A37A, *available at* http://www.nytimes.com/2010/11/07/us/politics/07ttmedicaid.html?scp=1&sq=emily%20ramshaw&st=cse (last visited Nov. 23, 2010); Janet Adamy & Neil King Jr., *Some States Weigh Unthinkable Option: Ending Medicaid*, The Wall Street Journal (Nov. 22, 2010), *available at* http://online.wsj.com/article/SB10001424052748704444304575628603406482936

id. at 30 n.23, the states' own behavior illustrates that they have the freedom to opt out, and that no procedural obstacle stands in their way.

D. The ACA's Medicaid Amendments Are Not "Coercive"

What is left of plaintiffs' coercion argument reduces to this: The states lack the free will to accept or reject the Act's Medicaid amendments because, on the one hand, the expansion allegedly imposes significant new costs on states that are already having trouble closing budget gaps, while on the other, the size or importance of federal Medicaid grants makes them too hard to turn down.

As an initial matter, under any set of facts consistent with plaintiffs' allegations, their challenge to the ACA's amendments to Medicaid may be decided as a matter of law. *See* Defs.' Mem. 41-50 (citing, *inter alia*, *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981)). This Court therefore need not resolve any disputed issues of fact — to the extent they may exist — regarding the size of the states' budget deficits or the Medicaid amendments' cost to the states, as such issues are not material and do not preclude summary judgment in favor of defendants. Indeed, defendants are aware of no case that has considered a state's budget deficit, or the cost to a state of a spending condition, material under the coercion theory. Rather, the cases have generally looked to the size of the "carrot," *Oklahoma*, 655 F.2d at 413 — that is, the federal grant itself — and have uniformly concluded that, whatever its size, a state remains free to accept or reject the grant and any attached conditions. This Court should do the same.

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1. Congress Is Not Barred From Offering Conditional Grants to States During Economic Downturns

Plaintiffs cite no support for the proposition that Congress's power to offer states a conditional grant turns on the strength or weakness of state finances at a particular moment. Certainly, there is no bar to offering federal funding to states during an economic downturn, even where those funds are attached to conditions that would obligate states to accept new duties or undertake new expenditures. *See, e.g.*, American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009) (temporarily increasing FMAP provided that states maintain existing Medicaid eligibility requirements even for optional groups). Indeed, the Medicaid amendments at issue here are almost entirely federally funded, and are predicted to generate significant economic growth in the states. *See, e.g.*, Kaiser Family Foundation, *Health Reform Issues: Key Issues About State Financing and Medicaid*, at 3 (May 2010) (Defs.' Ex. 37). If the law were otherwise, Congress would be restricted to offering conditional grants during times of economic surplus, when they are *least* needed. In fact, Congress would have to evaluate *each* state's budget before modifying a federal spending program, because *any* state with a budget in the red could claim coercion — and the constitutionality of a nationwide program might turn on the finances of a single state.

Plaintiffs' budget argument also suffers from a glaring disconnect: The states rely on *current* budget deficits to claim that they are coerced by alleged costs that, aside from certain administrative expenses (for which matching is also available), would not be incurred for at least *three to six years* — no earlier than 2014 (for any currently Medicaid-eligible individuals who might enroll) and as late as 2017 (when, for the newly eligible, the FMAP decreases from 100 percent to 95 percent). There is no telling what the states' economic situations will be like then.

Also overstated is plaintiffs' claim that the Act's maintenance-of-effort provisions "lock them into providing optional benefits" and "strip State flexibility" to control their budgets. Pls.' Mem. 38, 41. Such provisions, which are hardly unprecedented,[18] have a more limited effect than plaintiffs would have the Court believe. Here, they preclude a state from tightening its Medicaid eligibility standards for adults until its exchange is operational — which, if run by the state, must be by 2014, *see* ACA § 1321(b)-(c); for children, eligibility standards must be maintained until 2019. ACA § 2001(b). They do not, however, prevent states from adjusting covered benefits, copayments, provider payment rates, and many other features of their programs — and thus leave states with significant discretion to control costs. In fact, 39 states restricted provider rates in FY 2010, and 37 states plan such restrictions for FY 2011. Vernon K. Smith et al., Kaiser Comm'n on Medicaid & the Uninsured, *Hoping for Economic Recovery, Preparing for Health Reform* 32 (Sept. 2010), *available at* http://www.kff.org/medicaid/upload/8105.pdf (last visited Nov. 21, 2010). Louisiana, for example, cut inpatient hospital rates by 12.1 percent in FY 2010 and an additional 4.6 percent in FY 2011. *Id.* at 34. Similarly, 20 states restricted benefits in FY 2010, and 14 plan such restrictions in FY 2011, *id.* at 32, including Arizona, which eliminated most dental care coverage, and Indiana, which limited mental health coverage, *id.* at 44. In any event, beginning in 2011, many states will largely be exempt from the maintenance-of-effort provisions: for states with budget deficits, those provisions will not apply

[18] Congress has included maintenance-of-effort provisions in several previous Medicaid expansions. *See, e.g.*, Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401(b), 100 Stat. 1874 (1986) (adding 42 U.S.C. § 1396a(*l*)(4)(A)) (conditioning optional coverage of pregnant women, infants, and children on maintenance of existing payment levels); Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101(e)(4), 101 Stat. 1330 (1987) (amending 42 U.S.C. § 1396a(*l*)(4)(A) to extend maintenance requirements); *cf.* American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5001(f), 123 Stat.115 (2009) (conditioning temporary increase in FMAP on maintenance of existing eligibility requirements).

with respect to individuals above 133 percent of the federal poverty who are not pregnant or disabled. ACA § 2001(b).

Plaintiffs are similarly mistaken to assert that states lack the ability to close budget gaps by reducing expenditures or raising revenue. Pls.' Mem. 32-33. Although exercising these options, like deciding whether to participate in Medicaid, may require difficult political choices, each state is ultimately "free to change its method of generating public income whenever [its] people wish to do so." *Nevada v. Skinner*, 884 F.2d 445, 448 n.5 (9th Cir. 1989). Florida, for example, is one of the handful of states that impose no personal income tax, Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source* (Defs.' Ex. 42), and its per capita tax burden is among the lowest in the nation, Fed'n of Tax Adm'rs, *2009 State Tax Revenue* (Defs,' Ex. 43). In fact, if Florida were to raise its per capita tax burden from its current level ($1,724) to the national average ($2,334), it could raise more than $11 billion, *see* Fed'n of Tax Adm'rs, *2009 State Tax Revenue* — more than enough to offset the $8.3 billion in federal Medicaid funds it received in 2008 (the most recent year for which published data is available), *see* Kaiser Family Foundation, *Federal & State Share of Medicaid Spending, FY2008* (Defs.' Ex. 39).[19] Nor are states simply unable to fund state-run programs for the medically needy outside of Medicaid, as plaintiffs suggest. Pls.' Mem. 25, 32-33. In fact, many states already fund such programs with

[19] Moreover, *Steward Machine* itself expressly rejected the notion that it matters for Spending Clause purposes that, if a state withdraws from Medicaid, "federal funds taken from [its] citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to the states that have agreed to continue participating in the program." Slip op. at 56 (cited in Pls.' Mem. 27, 33). There, in rejecting a coercion claim where states that declined to create unemployment insurance funds stood to lose up to a 90 percent share of federal unemployment taxes — totaling hundreds of millions of dollars — the Court noted that "[i]f some of the states hold out in their unwillingness to pass statutes of their own, the receipts" collected by the federal government and not returned to the states "will be still larger." *Steward Machine*, 301 U.S. at 586 n.8.

state dollars alone. *See, e.g.*, Council of Economic Advisers ("CEA"), *The Impact of Health Insurance Reform on State and Local Governments*, at 34-35, 85 (Sept. 15, 2009) (Defs.' Ex. 33) (describing Pennsylvania's adultBasic program and the Healthy Indiana Plan). Indeed, Arizona provided medical care to its low income citizens outside of Medicaid until 1982, when it first joined the program. *See Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219, 1226 (9th Cir. 2010).

2. Plaintiffs Overstate the Costs and Understate the Savings from the ACA

The CBO estimates that, under the ACA, federal Medicaid outlays will increase by $434 billion, and state outlays by $20 billion, through the end of the decade. Letter from Douglas Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps. tbl.4 (Mar. 20, 2010) (Defs.' Ex. 32) [hereinafter CBO Letter to Speaker Pelosi]. But even this relatively small increase in state Medicaid spending will be more than offset by savings to states created by other ACA provisions, Defs.' Mem. 40-41 & n.12, which plaintiffs fail to take into account.

Plaintiffs submit declarations containing Medicaid cost projections for 11 states. None of them accounts for projected savings from the downsizing or elimination of existing state-funded programs that may no longer be necessary in light of the Medicaid expansion and the federal tax credits for coverage sold on exchanges. *See* Defs.' Mem. 40. Likewise, no state accounts for the ACA's expected reductions in the cost of uncompensated care — such as the "hidden tax" on employees' health insurance premiums — currently borne in part by state and local governments. *See id.* at 40-41 & n.12. Savings to states from these two areas alone are estimated at $66 billion to $80 billion over the 2014-2019 period, easily offsetting the $20 billion in new state Medicaid spending the CBO expects over the same time frame. *See id.* at 41 &

n.12.[20] And these figures do not include other fiscal benefits to states, such as increased economic activity that will create jobs and tax revenues. Kaiser Family Found., *Health Reform Issues: Key Issues About State Financing and Medicaid*, at 3 (May 2010) (Defs.' Ex. 37).

Moreover, the plaintiff states' declarations overstate the costs of the ACA by making significant errors and omitting critical facts. For example:

- *Information technology ("IT") costs*. Many states' projections include the costs of upgrading computer equipment or programming new systems to implement the Medicaid expansion or to administer exchanges, the former of which ordinarily would be reimbursed at a 50 percent matching rate. *See, e.g.*, Pls.' Mem. Ex. 2 ¶ 9-10 (Florida); Ex. 9 ¶ B.4 (Arizona); Ex. 12 ¶ B.4 (Louisiana); Ex. 13, Attach. B, at 1 (North Dakota); Ex. 16 ¶¶ 9-10 (Nevada). However, CMS recently issued a proposed rule that would provide for extraordinarily enhanced matching rates — 90 percent for the design and development of new systems, and 75 percent for maintenance and operations — and thus substantially reduce any new IT costs. *See* 75 Fed. Reg. 68583 (Nov. 8, 2010). In addition, under the ACA, states may apply for federal grants to fully fund the costs of establishing and operating exchanges through 2014, including costs to design and implement new IT infrastructure. *See* ACA § 1311(a); Press Release, U.S. Dep't of Health & Human Servs., *HHS Announces New Competitive "Early Innovator" Grants* (Oct. 29, 2010), *available at* http://www.hhs.gov/news/press/2010pres/10/20101029a.html (last visited Nov. 23, 2010).

- *Payment rates for primary care physicians*. The ACA sets the minimum payment for Medicaid primary care physician services "furnished in 2013 and 2014" by a physician with a certain primary specialty designations at the Medi*care* rate, and provides for 100 percent federal reimbursement of the cost of meeting this requirement during those years. HCERA § 1202. States therefore do not contribute to the 2013 and 2014 increased payment rates. The ACA imposes no such requirement beyond 2014. Nevertheless, several states improperly assume that they will continue to pay these increased rates at regular FMAPs in later years. *See* Pls.' Ex. 1 ¶ 13 (Florida); Ex. 10 ¶ 7 (Indiana); Ex. 12 ¶ B.3

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[20] *See also* CEA, *The Impact of Health Insurance Reform on State & Local Governments*, at 6-7 (Defs.' Ex. 33) (estimating savings at $11 billion *per year* after 2013); John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [ACA] on the States?*, at 2 (June 2010) (Defs.' Ex. 35) ($70-80 billion over 2014-2019); J. Angeles, Center on Budget and Policy Priorities, *Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law*, at 10 (Oct. 21, 2010) (Defs.' Ex. 36) (uncompensated care savings "may fully offset" any new state outlays) [hereinafter *Reports Overstate the Effect on State Budgets*].

(Louisiana); Ex. 16 ¶ 3 (Nevada); Ex. 20 at 5 (Texas). One state (Nebraska) even assumes that it will raise payment rates for *all* physician services — not just primary care physician services — although that is not required even in 2013 and 2014. *Id.* Ex. 14, Attach. A, at 6. But, as plaintiff Nevada concedes, the ACA imposes no such requirements. *Id.* Ex. 16 at 3 ¶ 3 ("The State will need to decide whether it will continue paying physicians at that level or to lower the rates after 2014."); *see also Reports Overstate the Effect on State Budgets*, at 6 (inset).[21]

- *Drug rebate percentages*. Under prior law, prescription drugs were generally ineligible for Medicaid coverage unless the manufacturer agreed to pay the federal government a rebate of at least 15.1 percent of the average manufacturer price for most drugs, and some states negotiated with manufacturers to obtain additional rebates above that floor. The ACA raises the minimum rebate for most drugs to 23.1 percent and provides that savings "attributable" to this increase will be "recaptured" by the federal government. ACA § 2501. Plaintiffs incorrectly assert that this provision requires states to "give up the value of drug rebates that [they] currently receive and which the federal government will expropriate to reduce its own costs." Pls.' Mem. 41; *see, e.g.*, *id.* Ex. 1 ¶¶ 28-30 (Florida); Ex. 14 ¶ 17 & Attach. A at 5 (Nebraska); Ex. 20 at 5-6 (Texas). In fact, CMS's most

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[21] Plaintiffs are wrong to claim that the ACA's estimated $143 billion in savings to the federal government over 2010-2019 "will come from deep reductions in compensation to physicians, hospitals, and other healthcare providers under Medicare — assuming that Congress does not continue (as it has in recent years) to intervene, on a year-to-year basis, to forestall reductions." Pls.' Mem. 41-42 n.41. For this statement, they rely on a Wall Street Journal op-ed asserting that, according to the CMS chief actuary, "Medicare payment rates for doctors and hospitals serving seniors will be cut by 30% over the next three years." Peter Ferrara & Larry Hunter, *How ObamaCare Guts Medicare*, The Wall Street Journal, Sept. 9, 2010. But those cuts are required not by the ACA, but by *prior law*, so they were in fact excluded from the CBO's cost projections, and appropriately so.

In the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997), Congress tied physician payment rates to a formula (the "sustainable growth rate" or "SGR" formula) based on the growth in GDP, physicians' actual costs, and Medicare enrollment. Over time, application of the SGR formula began to yield relatively large cuts in payment rates, and every year since 2003, Congress has prevented the full cuts from taking effect, although it has not modified the SGR formula, which remains law. Paul N. Van de Water, Center on Budget and Policy Priorities, *The Sustainable Growth Rate Formula and Health Reform*, at 1 (Apr. 21, 2010), *available at* http://www.cbpp.org/cms/index.cfm?fa=view&id=3166 (last visited Nov. 23, 2010). It was to the cumulative effect of this annual "doc fix" that the CMS chief actuary was referring when he wrote that "[c]urrent law" — that is, the Balanced Budget Act, not the ACA — "would require physician fee reductions totaling an estimated 30 percent over the next 3 years" if the SGR cuts were allowed to take effect. *See* Bds. of Trustees of Fed. Hosp. Ins. & Fed. Supp. Med. Ins. Trust Funds, *2010 Annual Report*, at 281 (Aug. 5, 2010), *available at* https://www. cms.gov/ReportsTrustFunds/downloads/tr2010.pdf (last visited Nov. 23, 2010).

recent guidance explains that the federal government will recapture only the amount by which rebates exceed prior-law levels; thus, states that were receiving additional rebates before the ACA will keep them. *See* CMS Letter to State Medicaid Directors at 1-3 (Sept. 28, 2010), *available at* http://www.cms.gov/smdl/downloads/SMD10019.pdf (last visited Nov. 23, 2010); *Reports Overstate the Effect on State Budgets*, at 9 (inset).

- *Medicaid participation rates*. Many states' cost projections are skewed upward because they unrealistically assume that, come 2014, *all* eligible individuals will *immediately* enroll in Medicaid. *See, e.g.*, Pls.' Mem. Ex. 9 ¶ C.1 (Arizona); Ex. 10 ¶ 10 & Attach. A at 3 (Indiana); Ex. 12 ¶ C.1 (Louisiana); Ex. 14 ¶ 20 (Nebraska); Ex. 16 ¶ C.1 (Nevada); Ex. 18 ¶ 13 (South Dakota). This assumption is not credible for budgeting purposes. Enrollment in Medicaid is not automatic, and no means-tested public program has ever achieved a 100 percent participation rate; for example, about 82 percent of eligible children currently participate in Medicaid and CHIP. *Reports Overstate the Effect on State Budgets*, at 4-5. More realistic projections assume a 50 percent participation rate in early years, ramping up over time, but never reaching 100 percent. *Id.* at 6.

A proper accounting shows that the Act's revenue-raising and cost-saving provisions more than offset any increase in state Medicaid outlays under the Act. For example, plaintiff Pennsylvania projects that, all told, the Act will *save* the state between $283 and $651 million through 2018. Press Release, Penn. Office of the Governor, *Governor Rendell Signs Order Starting to Implement Health Care Reforms* (May 19, 2010), *available at* http://www.governor.state.pa.us/portal/server.pt/community/news_and_media/2999/news_releases/665417 (last visited Nov. 23, 2010). Likewise, Maryland estimates a savings of $621 million to $1 billion through 2020. Md. Health Care Reform Coord. Coun., *Interim Report*, Appendix F, at 23 (July 26, 2010), *available* at http://www.healthreform.maryland.gov/interimreport.html (last visited Nov. 23, 2010). Plaintiffs' estimates to the contrary are incomplete and inaccurate — not to mention irrelevant to the constitutionality of the ACA's amendments to Medicaid.

3. The Size or Importance of Federal Medicaid Grants Does Not Render Them Unconstitutionally Coercive

In the end, plaintiffs are left to argue that federal Medicaid grants are so large or important that states have "no choice" but to accept them. Specifically, they submit that a conditional spending program is rendered unconstitutionally coercive when the entire amount of a large federal grant is at stake: "[T]he coercion doctrine unquestionably applies where Congress adopts an all-or-nothing strategy with enormous federal funding consequences to impose requirements on the States which it could not lawfully impose by other means." Pls.' Mem. 28. Plaintiffs might wish this were the law, but it is not. Instead, as defendants have explained, court after court has rejected claims of coercion where the entire amount of a large federal grant is at stake — including entire Medicaid grants. *See* Defs.' Mem. 47-48; *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (entire Medicaid grant); *Padavan*, 82 F.3d at 29 (entire Medicaid grant); *Oklahoma*, 655 F.2d at 414 (entire Medicaid grant); *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (entire federal education grant); *Kansas v. United States*, 214 F.3d 1196, 1198 (10th Cir. 2000) (entire federal welfare grant); *Van Wyhe v. Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (entire federal grant for state prisons). Plaintiffs' assertion that the federal Medicaid grant at stake here "dwarf[s]" the grants "at issue in any other case cited in this litigation," Pls.' Mem. 32, is simply wrong.

Plaintiffs' attempt to invoke the Fourth Circuit's approach to the coercion theory is misleading and ultimately unavailing. Plaintiffs assert that "the Fourth Circuit has deemed the coercion theory viable where the federal government threatens an entire block of federal funds." Pls.' Mem. 28-29. That misstates the Fourth Circuit's test, which has no application here. In fact, the Fourth Circuit has indicated that a coercion claim might lie, if at all, where the federal

government "'withholds the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some *insubstantial* respect.'" *West Virginia*, 289 F.3d at 291 (emphasis added) (quoting dictum from *Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (en banc) (opinion of Luttig, J.)). That disproportionality test is not met here, where the challenged condition — the expansion of Medicaid eligibility to a new group of categorically needy — is not "insubstantial" but a core requirement. Moreover, the Fourth Circuit has held that, in a facial challenge such as this one, "the mere possibility" that a state could lose all of its Medicaid funds does not establish unconstitutional coercion given that the Secretary has discretion under the Medicaid Act, 42 U.S.C. § 1396c, to withhold only part of a state's Medicaid funds. *West Virginia*, 289 F.3d at 291-94 (citing *United States v. Salerno*, 481 U.S. 739, 745 (1987)). In any event, application of the Fourth Circuit's test here is foreclosed by *Benning v. Georgia*, 391 F.3d 1299, 1308 (11th Cir. 2004), which rejected the notion that a state may disregard a spending condition that imposes a burden it deems disproportionate to the benefit conferred by the accompanying grant: "[T]here is no standard of proportionality for spending legislation. . . . If a State wishes to receive any federal funding, it must accept the related, unambiguous conditions in their entirety." *Id.* (citation omitted). Thus, even if the Fourth Circuit's interpretation of the coercion standard were satisfied here — and it is not — that test could not be applied in the Eleventh Circuit.[22]

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[22] Plaintiffs' reliance on *College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board*, 527 U.S. 666 (1999) — which is not even a Spending Clause case — is misplaced. Pls.' Mem. 29-30. There, the Supreme Court considered whether section 43(a) of the Lanham Act permitted a false advertising claim against a state. The Court held that it did not because (1) the provision did not validly abrogate state sovereign immunity under section 5 of the Fourteenth Amendment; and (2) the state had not waived its sovereign immunity merely by participating in the regulated activity (selling certificates of deposit designed to finance the costs of college). 527 U.S. at 668, 671-76. In response to the dissent's argument that finding a constructive waiver of immunity would be no more "coercive" than typical conditional spending

E. The ACA's Medicaid Amendments Satisfy the "General Restrictions" on the Spending Power

Plaintiffs also argue — for the first time — that the ACA's Medicaid amendments violate the four "general restrictions" on the spending power set forth in *Dole*. Pls.' Mem. 44-45 (citing *Dole*, 483 U.S. at 207); *see* slip op. at 52 (noting that "plaintiffs do not appear to dispute that the Act meets these restrictions"). They devote less than a page to the argument, and it can be dispatched nearly as quickly.

First, legislation under the Spending Clause must pursue the "general welfare," U.S. Const. art. I, § 8, cl. 1. *Dole* made clear that the judiciary must "defer substantially" to congressional judgment on this issue and, indeed, questioned "whether 'general welfare' is a judicially enforceable restriction at all." *Dole*, 483 U.S. at 208 n.2 (citing *Buckley v. Valeo*, 424 U.S. 1, 90-91 (1976)). Here, Congress found that achieving broader health care coverage would "increase the number and share of Americans who are insured," lessen the drag on the economy caused by the "poorer health and shorter lifespan of the uninsured," and reduce the "cost of providing uncompensated care to the uninsured" passed on to the insured and to taxpayers. ACA §§ 1501(a)(2), 10106(a). These findings merit substantial deference. *Dole*, 483 U.S. at 208 n.2.

Second, Congress must clearly state the conditions on the receipt of federal funds to afford states notice of their obligations. *Id.* at 207. Plaintiffs' suggestion that the Medicaid

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legislation, Justice Scalia, writing for the majority, drew a bright-line rule: "[T]he point of coercion is *automatically* passed" where "the constitutionally guaranteed protection of the States' sovereign immunity is involved." *Id.* at 687 (emphasis added). By contrast, he emphasized that "spending power" cases — like this one — involve "fundamentally different" principles: "Congress has no obligation to use its Spending Clause power to disburse funds to the States; such funds are gifts." *Id.* at 686-87. Plaintiffs' attempt to blur this distinction fails. As the Eleventh Circuit has cautioned, when evaluating Spending Clause legislation, cases like *College Savings* that do not "involve[] conditions imposed on the receipt of federal funds by states . . . 'are inapposite.'" *Benning*, 391 F.3d at 1308 (citation omitted).

amendments fail this prong because they were unforeseeable in 1965, when the first group of states "originally opted into Medicaid," Pls.' Mem. 36-37, is puzzling because, in the same breath, plaintiffs assert that Medicaid is an "ongoing, cooperative program[]" in which "the conditions applicable to any particular . . . grant are those in force at the time that grant is made." *Id.* at 37 (citing *Bennett v. Ky. Dep't Educ.*, 470 U.S. 656, 669 (1985)). To participate in Medicaid, a state must submit a plan demonstrating compliance with *current* statutory and regulatory requirements, *see* 42 U.S.C. § 1396a; 42 C.F.R. § 430.10, and if the plan is approved, the federal government makes grant awards on a quarterly basis, *see* 42 C.F.R. § 430.30. Thus, the inquiry is not whether the state is complying with the terms of the Medicaid statute as it existed when the state first entered the program. Under plaintiffs' own logic, the spending conditions relevant to whether a state "voluntarily and knowingly" accepts the terms of the Medicaid bargain, Pls.' Mem. 37 (citation omitted), include those imposed by the ACA.

Plaintiffs also suggest that *Dole*'s second prong is violated because states are unsure how their medically needy residents would fare in the absence of Medicaid. Pls.' Mem. 34-35. But that is not the test. In fact, the test focuses on the clarity of the conditions that states must meet when they accept federal funds, not a prediction of how states can cope with their own decisions not to accept federal money or the conditions that come with it. *See West Virginia*, 289 F.3d at 294 (given its complexity, the Medicaid Act "deal[s] with the myriad forms of non-compliance in an entirely reasonable manner, by setting forth in broad terms the consequences for failure to comply"). Here, the challenged spending condition (expansion of Medicaid eligibility to low-income childless adults) and the consequences of declining to comply (potential loss of entire federal Medicaid grant) are crystal clear, "enabl[ing] the States to exercise their choice knowingly." *Dole*, 483 U.S. at 207 (alteration in original). *Dole*'s second prong requires

nothing more.

Third, spending conditions "might be illegitimate" if unrelated to the purpose of the grant program. *Id.* at 207. Here, the link between the condition and the federal interest is direct, as the challenged condition defines the terms of eligibility for the very program Congress is funding, rather than conditioning funding on the acceptance of subsidiary requirements. *Cf. Dole*, 483 U.S. at 208-09 (conditioning grant of federal highway funds on establishment of minimum drinking age).

Fourth, the conditions may not require "the States to engage in activities that would themselves be unconstitutional." *Id.* at 210. Plaintiffs identify no such activities. Pls.' Mem. 45.

Thus, the Act's conditions on the receipt of federal Medicaid funds satisfy each of the "general restrictions" set forth in *Dole*, and are an unexceptional exercise of the spending power.

IV. MOST OF THE REMAINDER OF THE ACA IS SEVERABLE FROM THE MINIMUM COVERAGE AND MEDICAID ELIGIBILITY PROVISIONS

Plaintiffs argue that if either their challenge to the minimum coverage provision or their challenge to the Medicaid eligibility provisions succeeds, then the entire ACA, including provisions that no plaintiff has standing to challenge, should be stricken as well.

This Court, even if it were to rule in plaintiffs' favor on their summary judgment motion, should defer until the remedies stage any decision on the extent to which other provisions of the Act would fall with the minimum coverage provision or Medicaid eligibility provisions. Working through the complex permutations presented by the issue of severability is an effort best undertaken in separate briefing if this case reaches that stage, instead of in response to parting shot in plaintiffs' summary judgment brief. *See Tanner Adver. Grp., LLC v. Fayette*

Cnty., Ga., 451 F.3d 777, 797 n.4 (11th Cir. 2006) (Birch, J., concurring) (noting that issues of severability arise at remedies stage, not merits stage).

In any event, if the issue were to be decided now, the vast majority of the ACA's provisions are severable from those challenged by plaintiffs. As the Supreme Court recently emphasized:

> Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact. Because the unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions, *the normal rule is that partial, rather than facial, invalidation is the required course*.

Free Enter. Fund v. Pub. Co. Accounting Oversight Bd., 130 S. Ct. 3138, 3161 (2010) (internal quotations omitted; emphasis added). Courts therefore must "strive to salvage" as *much* of a statute as possible, as only the statute, and not the court's ruling, is a product of the democratic process: "[W]e try not to nullify more of a legislature's work than is necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006) (internal quotation omitted).

Against this presumption in favor of severability, and in the absence of a statutory provision expressly addressing severability, courts apply a two-part test. First, after finding a portion of a statute unconstitutional, the court determines whether the remaining portions remain "fully operative as a law"; if so, the remainder is "presumed severable." *INS v. Chadha*, 462 U.S. 919, 934 (1983). Second, that presumption can be defeated if the court finds that it is "*evident*" that Congress would have preferred the rest of the statute (or particular portions) to be invalidated along with the unconstitutional provision. *See Free Enterprise Fund*, 130 S. Ct. at 3161-62 (emphasis supplied); *see also Ayotte*, 546 U.S. at 330.

Under these principles, *some limited set* of provisions of the Act cannot survive if the minimum coverage provision is stricken. As defendants repeatedly have made clear — in passages that plaintiffs inflate beyond their obvious meaning — the guaranteed issue and community rating insurance industry reforms in Section 1201 will stand or fall with the minimum coverage provision. As noted, these reforms within Section 1201 protect the 57 million Americans with pre-existing medical conditions by requiring insurers to issue policies to those persons at non-discriminatory rates. As plaintiffs correctly recognize, *see* Pls.' Mem. 2, these regulations of the interstate insurance market must be coupled with the minimum coverage provision in order to be effective. Absent a minimum coverage provision, the guaranteed-issue and community-rating reforms in Section 1201 would incentivize many to drop coverage, leading to a spiral of increased premiums and a shrinking risk pool — the insurance market would "implode." Because Congress would not have intended this result, these reforms cannot be severed from the minimum coverage provision.

Other parts of the statute, however, are plainly severable from both the minimum coverage provision and the Medicaid eligibility provisions. The Act, for example, prohibits discrimination against providers who will not furnish assisted suicide services. ACA § 1553. It sets up an "Independence at Home" demonstration project for chronically ill senior citizens. *Id.* § 3024. It provides for a special Medicare enrollment period for disabled veterans. *Id.* § 3110. It addresses Medicare reimbursement for bone-marrow density tests. *Id.* § 3111. It includes provisions for improving women's health. *Id.* § 3509. It includes provisions to improve dementia and abuse prevention training. *Id.* § 6121. As this Court has already held, slip op. at

14, the Act includes many tax provisions as well.[23] These and countless other provisions of the Act are entirely capable of being applied even if either or even both the minimum coverage and Medicaid eligibility provisions were struck down. It is far from "evident" that Congress would have preferred all of these provisions to be invalidated if the minimum coverage or Medicaid eligibility provisions were to fall.[24]

Plaintiffs arguments that, as long as the Court is striking down the minimum coverage provision, it might as well also reach out to strike down, for example, the Indoor Tanning Service tax, ACA § 10907, rely in part on what they call the "highly instructive" lack of a severability clause, which plaintiffs argue "speaks volumes." Pls.' Mem. 47. The Supreme Court disagrees: "In the absence of a severability clause, . . . Congress's silence is just that — silence — and does not raise a presumption against severability." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 686 (1987).

Plaintiffs also would propose that the Court, in effect, transform itself into a House or Senate whip and start counting votes. They argue that, since the Act passed by a "slender margin," then it must be "speculative" that any other provision could have passed without the challenged provisions. Pls.' Mem. 48. But it is not defendants' burden to prove, or even

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[23] With respect to the tax provisions of the Act, plaintiffs' new severability arguments represent a bait-and-switch when compared to the arguments in their opposition to the motion to dismiss. Plaintiffs persuaded the Court that the Anti-Injunction Act does not bar injunctive relief *because* the provisions they challenge are *not* taxes. Slip op. at 7-26. Yet now they demand an injunction against the entire Act including the provisions that this Court has already identified as tax provisions.

[24] Indeed, even if the Medicaid *eligibility* provisions on which plaintiffs focus their fire were invalidated, even many of the other Medicaid provisions would clearly be severable. One example is Section 2703, which provides states with the option to deliver Medicaid services to individuals with chronic health conditions under a coordinated and comprehensive care management model. Under this provision states will receive enhanced federal funding for the first eight quarters in which they implement the health home option. ACA § 2703.

speculate, that the rest of the bill would have passed without the challenged provisions. The burden is instead on plaintiffs to show that it is "evident" that Congress would have preferred the rest of the statute (or particular portions) to be invalidated along with the unconstitutional provisions. *Free Enterprise*, 130 S. Ct. at 3161-62. Plaintiffs' own speculation that Congress would prefer the other provisions of the Act to be invalidated does not even come close to making that conclusion evident.

V. PERMANENT INJUNCTIVE RELIEF IS NOT WARRANTED

Plaintiffs argue that, in the event the Court declares one or more provisions of the ACA invalid, it should also issue a permanent injunction. But injunctive relief is an "extraordinary remedy." *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982). To obtain such relief, a plaintiff must demonstrate *each* of the following:

> (1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction.

eBay, Inc. v. MercExchange, LLC, 547 U.S. 388, 391 (2006). Plaintiffs have not done so.

First, plaintiffs have not shown that they are threatened with irreparable injury now from provisions that will not go into effect until 2014.[25]

Second, plaintiffs have not shown that a lesser extraordinary remedy, such as a declaratory judgment, would be inadequate. "An injunction is a drastic and extraordinary remedy, which should not be granted as a matter of course. If a less drastic remedy . . . [would

[25] To be sure, the Medicaid eligibility provisions will require some preparatory work before 2014. But federal funding under the Act to pay for some of those expenses is also dependent on the Act. An effect of plaintiffs' proposed injunction against the entire Act would obviously be to turn off those federal payments to the states that could no longer serve the purposes Congress intended.

be] sufficient to redress [plaintiffs'] injury, no recourse to the additional and extraordinary relief of an injunction [is] warranted." *Monsanto Co. v. Geertson Seed Farms*, 130 S. Ct. 2743, 2761 (2010). Plaintiffs do not even try to explain why a declaratory judgment would not be adequate to vindicate their claims. Yet there is a long-standing presumption that a declaratory judgment provides adequate relief as against an executive officer, as it will not be presumed that that officer will ignore the judgment of the Court after appellate review is exhausted. *See Comm. on Judiciary of U.S. House of Representatives v. Miers*, 542 F.3d 909, 911 (D.C. Cir. 2008).

Third, the balance of harms and the public interest counsel against the issuance of an injunction. The Supreme Court has cautioned that "courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *Romero-Barcelo*, 456 U.S. at 312. "The public interest may be declared in the form of a statute." *Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 512 F.3d 1112, 1127 (9th Cir. 2008) (internal quotation omitted). Where the elected branches have enacted a statute based on their understanding of what the public interest requires, this Court's "consideration of the public interest is constrained . . . for the responsible public officials . . . have already considered that interest." *Id*. at 1126-27. Indeed, "a court sitting in equity cannot ignore the judgment of Congress, deliberately expressed in legislation." *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 497 (2001) (internal quotation omitted). Here, Congress determined that the public interest required it to enact a statute to expand coverage, to lower premiums, and to protect the 57 million Americans who have pre-existing medical conditions from the continuing threat that they will be unable to obtain, or that they will lose, needed insurance coverage. Congress has likewise determined it to be in the public interest to expand the federal offer of voluntary funding for the Medicaid safety net to cover millions of needy Americans. This Court

sitting in equity would not be free to disregard those judgments, even if plaintiffs had offered any comparable harm at the other end of the balance. Plaintiffs have not done so, and their request for an injunction should be denied.

CONCLUSION

For the foregoing reasons, plaintiffs' motion for summary judgment on Counts One and Four of the Amended Complaint should be denied.

Dated: November 23, 2010

Respectfully submitted,

TONY WEST
Assistant Attorney General

IAN HEATH GERSHENGORN
Deputy Assistant Attorney General

THOMAS F. KIRWIN
United States Attorney

SHEILA LIEBER
Deputy Director

/s/ *Eric Beckenhauer*
BRIAN KENNEDY, D.C. Bar No. 228726
Senior Trial Counsel
ERIC B. BECKENHAUER, Cal. Bar No. 237526
Trial Attorney
U.S. Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Ave. NW
Washington, DC 20530
Telephone: (202) 514-3338
Facsimile: (202) 616-8470
E-mail: eric.beckenhauer@usdoj.gov

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2010, the foregoing document was filed with the Clerk of Court via the CM/ECF system, causing it to be served on Plaintiffs' counsel of record.

/s/ *Eric B. Beckenhauer*
ERIC B. BECKENHAUER

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

STATE OF FLORIDA, by and through BILL McCOLLUM, *et al.*,	)	
Plaintiffs,	)	
v.	)	Case No. 3:10-cv-00091-RV/EMT
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,	)	
Defendants.	)	

DEFENDANTS' RESPONSE TO PLAINTIFFS' "STATEMENT OF MATERIAL FACTS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT"

Pursuant to Local Rule 56.1, defendants hereby respond to plaintiffs' statement of material facts in support of plaintiffs' motion for summary judgment." Defendants use below the same paragraph numbering as plaintiffs' statement.

1. This paragraph does not contain "facts" other than facts showing that the Patient Protection and Affordable Care Act ("ACA") was duly enacted into law.

2. This paragraph contains statements about the law, rather than facts.

3. This paragraph contains plaintiffs' characterization of section 1501 of the ACA, rather than facts. The text of section 1501, *q.v.*, is not in dispute.

4. This paragraph contains legal argument rather than facts. The legal argument is that Congress relied solely on its commerce power, and in particular that it did not rely on its power to tax and spend for the general welfare. The Court's ruling on the motion to dismiss

accepted that legal argument, so it is the *law* of the case for purposes of this motion. (Defendants' not having revisited the issue in their motion for summary judgment is, of course, without prejudice to their right to argue that legal point in any appellate proceedings.) The proposition that Congress relied solely on the commerce power, however, is not an assertion of *fact*, let alone an undisputed assertion of fact. "The question of the constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise." *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948). Thus, that Congress did not make unnecessary *recitals* of reliance on its power to tax and spend does not imply that ACA § 1501 is not supported by the power of Congress to tax and spend for the general welfare.

5. This paragraph, again, sets forth legal argument, rather than facts. Congress has, in any event, previously required Americans to purchase goods and services, including the required purchase of firearms and ammunition by all free males (Second Militia Act of 1792, ch.38, § 1, 1 Stat. 264, 265), and the required purchase of insurance in a wide variety of contexts.

6. This paragraphs contains a discussion of one dictionary meaning of "activity" rather than any facts.

7. This paragraph does not set forth any facts, but instead refers to laws enacted in several plaintiff states that purport to nullify portions of section 1501 of the ACA.

8. This paragraph does not set forth any facts, but instead consists of legal argument and characterizations of various provisions of the ACA.

9. It is not disputed that plaintiffs Brown and Ahlburg do not now have what would, in 2014, be qualifying health care coverage. However, the only evidence submitted with respect to their future intentions, is, at best, ambiguous on their future intents. Neither the declaration of Brown nor that of Ahlburg clearly states either 1) that the declarant will desire not to purchase

qualifying insurance even if it turns out that the purchase would be financially advantageous; or 2) that the declarant currently predicts that he or she will not desire to buy insurance because he or she is making an empirical prediction that the purchase will not be financially advantageous. To whatever extent plaintiffs are making an empirical claim, it is not one supported by record evidence. The declarations are silent about almost every fact that might be relevant (plaintiffs' current health status, for example). The declarations do disclose plaintiffs' ages (Brown is 55, Ahlburg 51, Brown Decl. ¶ 1; Ahlburg Decl. ¶ 1), but the age of the declarants tends to cut against any such empirical claim because of the ACA's limitation on age banding starting in 2014.

10. The first sentence is undisputed. The second sentence, alleging that NFIB members "must arrange their affairs to comply with the Individual Mandate, which will require the diversion of resources that otherwise could be used for their businesses," is conclusory. The declarations of NFIB members indicate that they will "investigate" the possible impact of the ACA, Brown Decl. ¶ 11, but it is not now possible, in advance of knowledge of either the premiums or coverage that will be available to plaintiffs in 2014, to come to any conclusion on that point. To the extent that the declarations state or suggest that NFIB members have pre-determined what they will conclude when they evaluate their options in 2013, those conclusions are not supported or supportable by specific facts.

11. Defendants do not deny the factual assertion that NFIB is educating its members about the ACA. However, insofar as plaintiff NFIB makes a legal assertion that the expenditure of resources for that educational purpose is sufficient to confer standing, defendants dispute that legal assertion as a matter of law. *See, e.g.*, *Nat'l Taxpayers Union v. United States*, 68 F.3d 1428, 1433-34 (D.C. Cir. 1995); *Ctr. for Law & Educ. v. Dep't of Educ.*, 396 F.3d 1152, 1161-62

(D.C. Cir. 2005).

12. Not material; partially disputed. Whether a state has a budget deficit at a particular moment is not material to whether a conditional spending program is a permissible exercise of Congress's authority under the Spending Clause. Defendants do not dispute that, when the ACA was enacted, many states had budget deficits.

Defendants dispute that the ACA fiscally harms states; to the contrary, on balance, it helps their budgets. See Defs.' MSJ 40-41 & n.12; CEA, *The Impact of Health Insurance Reform on State and Local Governments*, at 7-8 (Sept. 15, 2009) (Ex. 33) [hereinafter *The Impact on States*]; John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [ACA] on the States?*, at 2 (June 2010) (Ex. 35) ("[S]tate and local governments would save approximately $70-80 billion over the 2014-2019 period by shifting [currently state-funded coverage] into federally matched Medicaid, clearly exceeding the new cost to the states of the Medicaid expansion."); J. Angeles, *Center on Budget and Policy Priorities, Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law*, at 10 (Oct. 21, 2010) (Ex. 36) [hereinafter *Recent Reports Overstate the Effect on State Budgets*] ("[S]tates' savings from no longer having to finance as much of the cost of providing uncompensated care to the uninsured may fully offset the small increase in Medicaid costs resulting from the Medicaid expansion."); Kaiser Family Foundation, *Health Reform Issues: Key Issues About State Financing and Medicaid*, at 3 (May 2010) (Ex. 37) (increases in federal Medicaid funding will generate economic activity at the state level, including jobs and state tax revenues); Bowen Garrett et al., Urban Institute, *The Cost of Failure to Enact Health Reform: Implications for States*, at 13 tbl.2B (Sept. 30, 2009) (Ex. 38) (absent reform, state Medicaid/CHIP spending estimated to increase 60.7 percent by 2019 even under best-case

scenario).

Defendants also dispute the assertion that states lack the means to close any budget gaps by, for example, reducing expenditures or raising revenue. Through the political process, each state is "free to change its method of generating public income whenever [its] people wish to do so." *Nevada v. Skinner*, 884 F.2d 445, 448 n.5 (9th Cir. 1989). *See also* Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source* (Defs.' Ex. 42) (six plaintiff states — Alaska, Florida, Nevada, South Dakota, Texas, and Washington — impose no personal income tax; three impose no corporate income tax; and one imposes no sales tax); Fed'n of Tax Adm'rs, *2009 State Tax Revenue* (Defs,' Ex. 43) (of the 10 states with the lowest per capita tax burden, 7 are plaintiffs here: Alabama, Arizona, Colorado, Florida, Georgia, South Carolina, South Dakota, and Texas).

13. Not material; partially disputed. Whether a conditional spending program would increase net outlays for state governments is not material to whether it is a permissible exercise of Congress's authority under the Spending Clause. Defendants do not dispute that the CBO projects that, over 2010 to 2019, the ACA will reduce the federal deficit by $143 billion. Defendants dispute that the ACA fiscally harms states. *See supra* ¶ 12.

14. Not material; disputed. Whether the ACA as a whole, or any of its provisions, decreases the federal government's net outlays for Medi*care* — a program that is not even at issue in this lawsuit — is not material to whether the ACA's amendments to Medic*aid* are a permissible exercise of Congress's authority under the Spending Clause. Defendants dispute that the federal government's savings are projected to come mainly from reductions in Medicare providers' compensation. In fact, the CBO's projections about the ACA's net effect on the federal budget are the sum of a broad mix of new expenditures, reduced outlays, and revenue-generating provisions. CBO Letter to Speaker Pelosi tbls. 2, 5.

For this statement, plaintiffs rely on a Wall Street Journal op-ed asserting that, according to the CMS chief actuary, "Medicare payment rates for doctors and hospitals serving seniors will be cut by 30% over the next three years." Peter Ferrara & Larry Hunter, *How ObamaCare Guts Medicare*, The Wall Street Journal, Sept. 9, 2010. But those cuts are required not by the ACA, but by *prior law* — specifically, the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997) (tying physician payment rates to a "sustainable growth rate" formula) — so they were appropriately excluded from the CBO's cost projections. *See* Paul N. Van de Water, Center on Budget and Policy Priorities, *The Sustainable Growth Rate Formula and Health Reform*, at 1 (Apr. 21, 2010); Bds. of Trustees of Fed. Hosp. Ins. & Fed. Supp. Med. Ins. Trust Funds, *2010 Annual Report*, at 281 (Aug. 5, 2010).

15. Not material; not facts but legal argument; partially disputed. Whether a conditional spending program would increase net outlays for state governments is not material to whether it is a permissible exercise of Congress's authority under the Spending Clause. Moreover, this paragraph contains not facts, but legal argument regarding the effects of the ACA's minimum coverage and Medicaid provisions. Defendants dispute that the ACA fiscally harms states. *See supra* ¶ 12. Defendants do not dispute the assertion (though it is not fact but legal argument) that, beginning in 2014, covered expenses for Medicaid enrollees who were already eligible for Medicaid before the ACA will be reimbursed at regular FMAPs.

16. This paragraph sets forth legal argument rather than fact, much less undisputed fact. The paragraph cites only to a law review article, and even that article makes only the modest claim that whether something like the minimum coverage requirement is appropriate "is likely to be judged differently by people with diverging ideologies and political allegiances." That article in turn cites to another article that proposes a different untested possibility for

covering pre-existing conditions that does not claim that it is the only method that could be used.

17. Not material; not facts but legal argument; refers to nonexistent or dismissed claims. No response is required to the assertion that the ACA requires states to "provide expanded benefits to all employees who participate in a State group plan" because it refers to the ACA's general insurance industry reforms (e.g., the bar on preexisting condition exclusions), which plaintiffs do not challenge. Likewise, no response is required to the assertion that the ACA requires states to "offer enrollment in a state group insurance plan to all [state employees] who work 30 or more hours a week," because it refers to a claim that has been dismissed. Slip op. at 42-47. These assertions are not material to any live claim.

18. Not material; not facts but legal argument; refers to nonexistent or dismissed claims. *See supra* ¶ 17; slip op. at 42-47.

19. Not material; not facts but legal argument; refers to nonexistent or dismissed claims. *See supra* ¶ 17; slip op. at 42-47.

20. Undisputed.

21. Not material; not facts but legal argument; disputed. This paragraph consists of legal argument regarding conditions on the receipt of federal Medicaid funds under the ACA, none of which is material. In any event, each is disputed. Even if the Medicaid Act's original purpose to assist states with the cost of medical assistance for "needy persons," *Harris v. McRae*, 448 U.S. 297, 308 (1980), were material — and it is not, as it is Congress's intent in the ACA that matters, *see id.* at 309 & n.12 — the ACA is consistent with that purpose. *See* 42 U.S.C. § 1396d(a) (providing for assistance to those "whose income and resources are insufficient" to meet the costs of medical care); 75 Fed. Reg. 45628, 45629 (Aug. 3, 2010) (those with incomes between 100 and 133 percent of the federal poverty level make just $10,830 to $14,404 per

year); Kaiser Family Foundation, *Survey of People Who Purchase Their Own Insurance* 4 (June 2010), *available at* http://www.kff.org/kaiserpolls/upload/8077-R.pdf (last visited Nov. 22, 2010) (average annual cost of health insurance (premiums and out-of-pocket costs) in the individual market is $4,530).

Moreover, the ACA's expansion of Medicaid was foreseeable. *See* 42 U.S.C. § 1396a note; *Bowen v. POSSE*, 477 U.S. 41, 53 (1986) (states enter Medicaid subject to, and on notice of, Congress's authority to amend the program); John Klemm, Ph.D., *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105, 106 (Fall 2000) (Ex. 31) (between 1966 and 2000, Medicaid enrollment expanded from 4 million to 33 million).

The ACA's maintenance-of-effort provisions do not eliminate state discretion to control Medicaid costs. Vernon K. Smith et al., Kaiser Comm'n on Medicaid & the Uninsured, *Hoping for Economic Recovery, Preparing for Health Reform* 32 (Sept. 2010), *available at* http://www.kff.org/medicaid/upload/8105.pdf (last visited Nov. 21, 2010) (39 states restricted provider rates in FY 2010, and 37 states plan to in FY 2011; 20 states restricted benefits in FY 2010, and 14 plan to in FY 2011).

Even if the states had standing to challenge ACA § 2304, which they assert makes them "not only responsible (with their federal partner) for reimbursing health care costs, but responsibility (without their federal partner) to provide health care services," plaintiffs concede that the provision is "unclear in its import and effect," Pls.' MSJ at 42 n.42, and "cannot be assessed until regulations are promulgated" by CMS, *id.* Ex. 16 at 2 ¶ 4, 4 ¶ 6 (Nevada); *see also id.* Ex. 18 ¶ 12 (South Dakota) (change "may . . . alter South Dakota's Medicaid program" but CMS "has provided no guidance on whether or how").

22. Not material; not facts but legal argument; disputed. Whether a conditional

spending program would impose new costs or responsibilities on state governments is not material to whether it is a permissible exercise of Congress's authority under the Spending Clause. Defendants dispute that the ACA fiscally harms states. *See supra* ¶ 12.

Plaintiffs' reference to 138 percent (rather than 133 percent) of the poverty level appears to incorporate Congress's adjustments to the use of income "disregards" in determining Medicaid eligibility. Medicaid eligibility for most groups is determined partly by income level. Historically, states have used a variety of income disregards to exclude certain amounts when evaluating an applicant's eligibility for medical assistance. These disregards vary widely from state to state, and have the effect of raising the eligibility ceiling for such programs, sometimes significantly. In the ACA, to achieve greater consistency, Congress eliminated states' use of such disregards to make income-based eligibility determinations for Medicaid, with certain exceptions (for example, for the elderly or disabled), ACA § 2002(a) (adding 42 U.S.C. § 1396a(e)(14)(B), (D)), and instead adopted a standard 5 percent disregard to be applied in determining an applicant's modified adjusted gross income, *id.* (adding 42 U.S.C. § 1396a(e)(14)(A), (I)). These changes take effect in 2014. *Id.* § 2002(c). *See also, e.g.*, Donna Cohen Ross et al., Kaiser Comm'n on Medicaid & the Uninsured, *Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP* (May 2008), *available at* http://www.kff.org/medicaid/upload/7776.pdf (last visited Nov. 22, 2010).

23. This paragraph does not set forth any facts, but instead consists of legal argument and characterizations of various provisions of the ACA.

24. Not material; not facts but legal argument; refers to nonexistent or dismissed claims. Whether a conditional spending program imposes immediate costs or responsibilities on

state governments is not material to whether it is a permissible exercise of Congress's authority under the Spending Clause. Moreover, this paragraph generally does not set forth facts, but instead consists of legal argument and characterizations of various provisions of the ACA. Nevertheless, defendants do not dispute that *some* plaintiff states "are devoting funds and resources now to prepare and implement changes" for continued participation in Medicaid or to establish exchanges. Defendants also do not dispute the assertion that the ACA's maintenance-of-effort provisions are currently in effect. No response is required to the assertion that "the States as employers must imminently expand benefits offered within their employer group insurance plans" because it refers to a claim that has been dismissed. Slip op. at 42-47.

25. This paragraph does not set forth any facts, but instead consists of legal argument. Even if the states had standing to challenge ACA § 2304, which they assert makes them "not only responsible (with their federal partner) for reimbursing health care costs, but responsibility (without their federal partner) to provide health care services," plaintiffs concede that the provision is "unclear in its import and effect," Pls.' MSJ at 42 n.42, and "cannot be assessed until regulations are promulgated" by CMS, *id.* Ex. 16 at 2 ¶ 4, 4 ¶ 6 (Nevada); *see also id.* Ex. 18 ¶ 12 (South Dakota) (change "may . . . alter South Dakota's Medicaid program" but CMS "has provided no guidance on whether or how").

26. Not material; disputed. Whether a conditional spending program would impose new costs or responsibilities on state governments is not material to whether it is a permissible exercise of Congress's authority under the Spending Clause. In any event, this paragraph is disputed. CMS's most recent guidance explains that the federal government will only recapture rebates above prior-law levels; thus, states that were receiving additional rebates before the ACA will keep them. *See* CMS Letter to State Medicaid Directors at 1-3 (Sept. 28, 2010), *available at*

http://www.cms.gov/smdl/downloads/SMD10019.pdf (last visited Nov. 23, 2010); *Recent Reports Overstate the Effect on State Budgets*, at 9 (inset). Defendants dispute that the ACA fiscally harms states. *See supra* ¶ 12.

27. Not material; disputed. Whether a conditional spending program would impose new costs or responsibilities on state governments is not material to whether it is a permissible exercise of Congress's authority under the Spending Clause. In any event, this paragraph is disputed. The ACA sets the minimum payment for Medicaid primary care physician services "furnished in 2013 and 2014" by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at the Medi*care* rate and provides for 100 percent FMAP during those years. HCERA § 1202. States therefore do not contribute to the 2013 and 2014 increased payment rates. The ACA imposes no such requirement beyond 2014, and plaintiffs improperly assume that they will continue to pay these increased rates at regular FMAPs in later years. As Nevada concedes, the ACA imposes no such requirements. *Id.* Ex. 16 ¶ 3 ("The State will need to decide whether it will continue paying physicians at that level or to lower the rates after 2014."); *see also Reports Overstate the Effect on State Budgets*, at 6 (inset). Defendants dispute that the ACA fiscally harms states. *See supra* ¶ 12.

28. This paragraph generally does not set forth facts, but instead consists of legal argument. Nevertheless, defendants do not dispute that one of the proposed findings in the Bipartisan Commission on Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005) — which Congress never acted upon — was that "Medicaid is the single largest Federal grant-in-aid program to the States, accounting for over 40 percent of all Federal grants to States." Defendants also do not dispute that in FY 2009 (not FY 2010), federal spending for Medicaid was about $251 billion, CBO, *The Long-Term Budget Outlook*, at 30 (Aug. 2010), or roughly 7

percent of total federal outlays; and that in FY 2008, state spending on Medicaid, as a proportion of total state expenditures, averaged 20.7 percent (although a majority of that state spending was funded by federal dollars). And although defendants do not dispute that the majority of federal revenues come from individual income taxes and social security or social insurance taxes, and that most payors of those taxes *reside* in the states, they note that those taxes are collected from *federal* taxpayers.

29. This paragraph generally does not set forth facts, but instead consists of legal argument. Defendants do not dispute that Florida collected about $32 billion in tax revenues in 2009, but note that the projected *federal* share of Medicaid spending — that is, the revenue that Florida could potentially lose if it withdrew from Medicaid — is not "more than half" of this amount. Defendants dispute the assertion that states lack the means to close any budget gaps by, for example, reducing expenditures or raising revenue. *See supra* ¶ 12. Defendants note that Florida is one of the handful of states that impose no personal income tax, Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source* (Defs.' Ex. 42), and its per capita tax burden is among the lowest in the nation, Fed'n of Tax Adm'rs, *2009 State Tax Revenue* (Defs,' Ex. 43).

30. This paragraph does not set forth any facts, but instead consists of legal argument.

31. This paragraph generally does not set forth facts, but instead consists of legal argument. Defendants dispute the assertion that states lack the means to close any budget gaps by, for example, reducing expenditures or raising revenue. *See supra* ¶ 12. Defendants also dispute the assertion that states are unable to fund state-run programs for the medically needy outside of Medicaid. Many states already fund such programs. *See, e.g.*, CEA, *The Impact on States*, at 34-35, 85 (describing Pennsylvania's adultBasic program and the Healthy Indiana Plan). Indeed, Arizona provided medical care to its low income citizens outside of Medicaid

until 1982, when it first joined the program. *See Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219, 1226 (9th Cir. 2010).

32. This paragraph does not set forth any facts, but instead consists of legal argument.

33. This paragraph does not set forth any facts, but instead consists of legal argument.

34. This paragraph generally does not set forth facts, but instead consists of legal argument. Defendants do not dispute that Medicaid pays for medical services for many needy persons. However, defendants dispute the assertion that states are unable to fund state-run programs for the medically needy outside of Medicaid, *see supra* ¶ 31, as well as the assertion that a state's withdrawal from Medicaid would necessarily be abrupt or harmful to current enrollees, given the options available to the state and the discretion afforded to the Secretary. *See, e.g.*, 42 U.S.C. § 1396b(a); 42 C.F.R. § 430.12; 42 U.S.C. § 1315(a); *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 291-94 (4th Cir. 2002).

35. This paragraph does not set forth any facts, but instead consists of legal argument.

Dated: November 23, 2010

Respectfully submitted,

TONY WEST
Assistant Attorney General

IAN HEATH GERSHENGORN
Deputy Assistant Attorney General

THOMAS F. KIRWIN
United States Attorney

SHEILA LIEBER
Deputy Director

/s/ *Eric Beckenhauer*
BRIAN KENNEDY, D.C. Bar No. 228726
Senior Trial Counsel

ERIC B. BECKENHAUER, Cal. Bar No. 237526
Trial Attorney
U.S. Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Ave. NW
Washington, DC 20530
Telephone: (202) 514-3338
Facsimile: (202) 616-8470
E-mail: eric.beckenhauer@usdoj.gov

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2010, the foregoing document was filed with the Clerk of Court via the CM/ECF system, causing it to be served on Plaintiffs' counsel of record.

/s/ *Eric B. Beckenhauer*
ERIC B. BECKENHAUER