No. 11-400

In The
Supreme Court of the United States

STATE OF FLORIDA, *et al.*,

Petitioners,

v.

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

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF *AMICI CURIAE* HEALTH LAW & POLICY SCHOLARS AND PRESCRIPTION POLICY CHOICES IN SUPPORT OF RESPONDENTS ON THE CONSTITUTIONAL VALIDITY OF THE MEDICAID EXPANSION

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[Together With The Health Law & Policy Scholars Listed On Inside Cover]

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QUESTION PRESENTED

The Medicaid expansion in Section 2001(a)(1)(C) of the Patient Protection and Affordable Care Act is one part of Congress's comprehensive effort to expand access to health care coverage. This expansion is not revolutionary, but builds on many prior statutory amendments to Medicaid. Nor does it alter the voluntary nature of the Medicaid program – as before, States remain free to decline federal funding. The Petitioners and their *amici* have mischaracterized the expansion to obscure these facts, hoping this Court will unravel this hard-fought legislative enactment.

The question presented is whether Congress may offer States generous additional funding for Medicaid, with spending conditions that entirely satisfy the four-part test in *South Dakota v. Dole*, 483 U.S. 203 (1987).

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INTEREST OF *AMICI CURIAE*[1]

Health Law & Policy Scholars are scholars who study and teach health law and policy in the United States. We seek to correct the factual record on the history and expansion of the Medicaid program, and thus to place this litigation in its proper context. The Medicaid expansion in the Patient Protection and Affordable Care Act is not revolutionary by any standard but is a step-wise extension, built on programs from various State laboratories of democracy over the years. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

Prescription Policy Choices is a nonprofit educational and public policy organization providing objective research and expertise on prescription drug policy.

STATEMENT

Medicaid is a cooperative federal-state program. States choosing to participate must submit a State plan for approval by the Secretary of Health and Human Services. While Medicaid gives States some

[1] This brief is submitted with the consent of the parties, as lodged with the Clerk per the Docket Sheets. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party. *Amici* have borne their own expenses, without support from any party. The Boston University School of Law provided *pro bono* assistance.

discretion in designing and administering their programs, since 1965 federal law has imposed numerous mandatory requirements, including categories of individuals and families who must be covered, services that States must provide, and requirements for administering the program. *Harris v. McRae*, 448 U.S. 297, 301 (1980) ("Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of [the Medicaid Act]."); 42 U.S.C. 1396a(a)(10).

Congress enacted Section 2001(a)(1)(C) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (ACA or Act),[2] to expand the Medicaid program, creating a new mandatory category of eligibility that States must cover beginning January 1, 2014. ACA §2001(a)(1)(C). This category includes children and adults under 65 with incomes up to 133% of the federal poverty level (FPL) who are not pregnant, eligible for Medicare, or otherwise eligible through another mandatory Medicaid category. *Id.* Petitioners' constitutional challenge focuses on this particular provision. States' Br. 7-8. Petitioners do not challenge any optional Medicaid features of the ACA, see, *e.g.*, ACA §2001(a)(4) (giving states an option to cover those with incomes up to 133% FPL prior to 2014); ACA §2401 (community first option to cover attendant-care services for those at

[2] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

risk of institutionalization). Neither do they challenge new mandatory administrative requirements for reporting adult quality of care for Medicaid enrollees, ACA §2701; major modifications to Medicaid drug coverage, ACA §§2501-2503; or increased primary care payment rates in Medicaid, ACA §1202 (as amended).

Petitioners claim that ACA §2001(a)(1)(C) is an "extreme and unprecedented abuse," changing the fundamental nature of Medicaid. States' Br. 23. But imposing new Medicaid mandatory provisions on States as part of a national health policy agenda is not unusual. Medicaid was enacted in 1965 as part of a suite of Social Security Act amendments that also created Medicare to provide health insurance for elderly retired workers. Since the beginning, Medicaid has been part of larger Congressional health policy programs. Also since the beginning, Medicaid has imposed mandatory eligibility, services, and administrative requirements on participating States. The ACA's inclusion of a new category of mandatory eligibility is not surprising and is in keeping with well-settled expectations.

Petitioners claim that the Act somehow radically departs from the first forty-seven years of Medicaid. States' Br. 7-8, 10-11, 23. It is nothing new, however, for Congress to enact mandatory Medicaid reforms as part of a comprehensive package addressing national health policy problems.

Petitioners give the impression that Congress has never expanded Medicaid with broader program conditions attached to State participation. States' Br. 5-6, 22. But on numerous occasions, Congress has required conditions for continued participation in the already-existing program. Congress has included mandatory Medicaid reforms – some related to eligibility, others to benefits and coverage, and still others related to payment and administration – in the mix of broader policy interventions designed to tackle problems that transcend any single solution in a pluralistic and multi-state health care system. See Kaiser Family Foundation, *Medicaid: A Timeline of Key Developments, 1965 – 2009*. Indeed, conditional Medicaid expansions to address national problems have been a hallmark of the program since its enactment. Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 St. Louis L.J. 403, 405 (2007); Sara Rosenbaum, *Medicaid*, 346 New Eng. J. Med. 635, 635 (2002). The following examples illustrate this important facet of Medicaid program history, undermining key assumptions in Petitioners' arguments about the supposedly unique constitutional injury inflicted by the Act.

A. Congress Has Previously Added New Mandatory Eligibility Categories to Medicaid

Petitioners are correct that in 1965, when Medicaid was first enacted, mandatory eligibility was typically tied to eligibility for federal-state cooperative welfare programs. States' Br. 2-3. However,

beginning in 1972, Congress amended Medicaid, adding mandatory federal eligibility requirements, often as one part of broader, national health policy goals. The ACA's new mandatory category for low-income children and adults, ACA §2001(a)(1)(C), is simply the latest example in this long-standing tradition of using Medicaid mandatory categories as an instrument of national health policy to guarantee the poorest American access to affordable health insurance. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era,* 9 J. Health Care L. & Pol'y 5, 16-22 (2006).

In 1972, Congress ended the federal-state cooperative welfare program for the aged, blind and disabled and replaced it with Supplemental Security Income (SSI). Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, §§201, 301. Congress revised Medicaid to reflect this new national policy and required States to either extend Medicaid to all those eligible for the new SSI program or, under the so-called 209(b) option, allow those with incomes above the State's old cooperative welfare program eligibility limits to qualify for Medicaid by deducting medical expenses from income. *Id.* §§209, 301, as amended by Pub. L. No. 93-66, 87 Stat. 152, §212 (1973); Gov't Br. 6.

Petitioners make much of the fact that the 1972 amendments allowed States two options to comply with the new national policy. States' Br. 4. Both options, however, were expansions. States did not

have the option to forgo expansion entirely. Gov't Br. 5-6.

In 1988, Congress went even further, completely de-linking Medicaid eligibility for children and pregnant women from federal-state cooperative welfare programs. Congress created new mandatory eligibility categories up to 133% FPL for children from birth to age 5 and pregnant women, and up to 100% FPL for children age 6-18. See Medicare Catastrophic Coverage Act of 1988 (MCCA), §302, Pub. L. No. 100-360, 102 Stat. 683 (adding 42 U.S.C. 1396a(a)(A)(10)(i), 1396a(l)); Omnibus Budget Reconciliation Act of 1990, §4601, Pub. L. No. 101-508, 104 Stat. 1388. States were required to cover everyone in these new mandatory categories. Congress did not offer States any choice, other than leaving Medicaid entirely.

B. Congress Has Previously Expanded Mandatory Medicaid Benefit Categories as Part of Broader National Child Health Policies

In 1967, Congress reacted to two national crises: rampant poor health among preschool children and the high rate at which young draftees were failing Army physical exams. Sara Rosenbaum et al., *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* 6-11 (2005). In response, Congress enacted a suite of reforms aimed at strengthening the education and training of pediatric health professionals and provided direct financing to public health departments to

identify, screen, and treat impoverished children and youth. Social Security Act Amendments of 1967, Title III, Pub. L. No. 90-248, 81 Stat. 821.

As part of this larger initiative, Congress dramatically expanded mandatory federal Medicaid coverage requirements, creating the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. EPSDT required States to cover, at minimum: a comprehensive health and developmental history; a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests; health education; vision, dental, and hearing services; and care needed to diagnose or treat an identified condition, even if that treatment is not otherwise available under a State's Medicaid plan. See 42 U.S.C. 1396d(r). EPSDT expanded the mandatory coverage standards for children to a level unequaled in public or private health insurance at the time. Sara Rosenbaum & Paul S. Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 Health Affairs 382, 383-384 (2007).

Since 1967, Congress has strengthened EPSDT several times, often over political objections from some States. See Alice Sardell & Kay Johnson, *The Politics of EPSDT Policy in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits*, 76 Milbank Q. 175, 186, 190-192, 197-198 (1998); Omnibus Budget Reconciliation Act of 1989, §6403, Pub. L. No. 101-239, 103 Stat. 2106 (further delineating the scope of EPSDT benefit, including an express mandate that States cover "Such other

necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan"); Deficit Reduction Act of 2005, §6044, Pub. L. No. 109-171, 120 Stat. 4 (requires States to preserve EPSDT coverage in benchmark packages); Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, §611, Pub. L. No. 111-3, 123 Stat. 8 (clarifying requirement to provide EPSDT in benchmark packages); ACA, §2201 (preserving EPSDT as part of the newly reconfigured benchmarks).

C. Congress Has Previously Imposed Mandatory Medicaid Reimbursement Rules as Part of Larger Efforts to Develop and Sustain a Health Care Safety Net for Medically Underserved Communities

Nearly one-third of America's population resides in medically underserved urban and rural communities. Sara Rosenbaum et al., *National Health Reform: How Will Medically Underserved Communities Fare?*, Policy Research Brief No. 10, 3 (2009). The needs of these communities are acute. Their inhabitants tend to be sicker, poorer, and older than the general population, are more likely to either be uninsured or to have public insurance, and have diminished access to health care providers. See Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform and Rural Economies*, 113 W. Va. L. Rev. 1, 5 (2010);

Kevin Grumbach et al., *Physician Supply and Access to Care in Urban Areas*, 16 Health Affairs 71, 78-79 (1997). Although some States invested in public hospitals and local health department services, a national, systematic approach was needed to support a health care safety net. See, *e.g.*, Health Resources and Services Administration, *Designation of Medically Underserved Populations and Health Professions Shortage Areas*, 73 Fed. Reg. 11232-11281 (Feb. 29, 2008).

In response, Congress established the National Health Service Corps in 1972 and added the Community Health Centers program three years later as basic components of Public Health Service Act programs to support services to underserved communities. Sara Rosenbaum et al., *Community Health Centers in an Era of Health System Reform and Economic Downturn: Prospects and Challenges* 1-2 (2009).

As part of national policies to support these communities and the safety net providers who serve them, Congress added mandatory reimbursement and administrative requirements to Medicaid. In 1981, Congress required States to provide enhanced reimbursement to hospitals that treat a disproportionate number of uninsured and Medicaid patients. Omnibus Budget Reconciliation Act of 1981, §2173, Pub. L. No. 97-35, 95 Stat. 357; see also Theresa A. Coughlin & David Liska, *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues* 1-2 (1997). In 1989, Congress required States to pay clinics designated as either rural health clinics or

federally qualified health centers at a special, typically higher, rate. Omnibus Budget Reconciliation Act of 1989, §6404, Pub. L. No. 101-239, 103 Stat. 2106.

These mandatory Medicaid reimbursement rules are yet another example of how Congress has used Medicaid to implement national health policies. While States retain discretion to design the outer limits of their Medicaid programs, Congress repeatedly has used mandatory Medicaid requirements to define the "very core." Gov't Br. 24, 26.

D. Congress Has Previously Imposed New Mandatory Quality Standards for Long-Term Care in Medicaid as Part of Broader Safety and Quality Efforts

The quality of nursing home care became a national concern in the mid-1980s, following numerous investigations of substandard care and patient safety problems. Institute of Medicine, *Improving the Quality of Care in Nursing Homes* 3-4 (1986). Because the financial base of the nursing home industry rests substantially on Medicare and Medicaid, Congress used these programs to reshape nursing home quality. In 1987, Congress enacted a detailed set of requirements addressing quality, resident safety, and residents' rights as conditions for Medicare and Medicaid certification. These conditions of participation required nursing homes to provide regular assessments of residents' functional capacities and written care plans based on these assessments; offer enumerated activities and services to residents; maintain staffing

levels by qualified personnel for specified hours; give residents transfer and discharge rights; and protect residents' funds. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §4211, 101 Stat. 1330.

In conjunction with these amendments, Congress required States to establish nurse aide competency evaluations, registries, and nursing facility administrator standards; evaluate each mentally ill or developmentally disabled resident annually to determine if they should be discharged; amend State plans to account for new federal requirements; and, most notably, conduct annual, unannounced, standardized surveys of long-term care facilities, with follow-up investigation of allegations of resident abuse and neglect. *Id.* at §§4201, 4202.

Once again, Medicaid mandatory requirements – this time mandatory requirements as to how States administer their programs – were added in the service of larger national health policy concerns.

E. Congress Has Previously Imposed New Mandatory Medicaid Requirements on States as Part of Medicare Part D Prescription Drug Coverage

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (MMA), represents another example of a national health policy problem that includes Medicaid as part of the solution. Jonathan Oberlander,

Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act, 32 J. of Health Pol., Pol'y & L. 187, 190-191 (2007). Republican leadership in Congress supported the MMA, but it was narrowly enacted with scant support from Democrats. *Id.*

The MMA was a response to the urgent need to extend affordable prescription drug coverage to the nation's Medicare beneficiaries, including 8.9 million individuals covered by both Medicare and Medicaid (dual eligibles). Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* 1 (2011). The Republican-led extension of the Medicare outpatient prescription drug benefit (Part D) to dual eligibles was entirely compulsory, not optional, for States.

Part D displaced each state's Medicaid prescription drug coverage program for dual eligibles. MMA §103. The legislation eliminated state options concerning Medicaid coverage of outpatient prescription drugs and established a single national program under direct federal control. Financing included compulsory State contributions (known as the "clawback") toward the cost of Part D. MMA §103. The expenditures were not nominal: the Congressional Budget Office estimated that States would pay a total of $155 billion in clawback payments to the federal government between 2007 and 2016. Cong. Budget Office, *The Budget and Economic Outlook: Fiscal Years 2007 to 2016*, at 59 (2006). In 2003, States protested the clawback, characterizing it as "an

unprecedented intrusion into each State's sovereignty." *Texas v. Leavitt*, 547 U.S. 1204 (2006) (mem.) (denying original jurisdiction to States seeking an injunction against implementation of the Part D clawback); Brief of Arizona et al. as Amici Curiae In Support of Pls., *Texas*, 547 U.S. 1204 (No. 135). Nevertheless, States have now successfully adapted their Medicaid programs to Part D's requirements.

F. Conclusion

The history of the Medicaid program is long and detailed. Our purpose in this Statement is to highlight several significant mandatory expansions since 1965 that Congress has enacted as part of larger national health policies. Petitioners characterize the ACA's mandatory eligibility expansion as an "extreme and unprecedented abuse," States' Br. 23, 39-42, because it works in tandem with other health legislation to accomplish the national health policy goal of making health insurance affordable for all Americans. If the mandatory expansion in ACA §2001(a)(1)(C) is indeed coercive – as Petitioners claim – then they must articulate why no previous Medicaid expansions have been coercive. In fact, Petitioners overstate the discontinuity in the Act. As history makes clear, these changes build on prior foundations and are by no means unprecedented.

SUMMARY OF THE ARGUMENT

The ACA's provisions expanding Medicaid eligibility are entirely consistent with the recognized scope of congressional spending power and the long-standing cooperative nature of the Medicaid program. Acknowledging that the ACA's Medicaid provisions clearly satisfy the four-part test in *South Dakota v. Dole,* 483 U.S. 203, 207-208 (1987), Petitioners now ask this Court to "fashion" new limits on the spending power. States' Br. 28, Gov't Br. 15-16. But the ACA amendments to Medicaid do not warrant a departure from established precedent and practice.

To merit novel judicial treatment of the Medicaid amendments, Petitioners must demonstrate that whatever they claim is wrong with Medicaid is entirely new and novel. As a baseline, the States' challenge cannot be understood to assert constitutional infirmity to tried and true features of the existing program. If there is a straw that breaks the camel's back, it must be constitutionally distinguishable from all previous straws in Medicaid. Petitioners fail in this task.

The federal government has for many decades used Medicaid as a tool to further larger, national health policy goals. The fundamental elements of Medicaid have long been mandatory. While unconditional block grants to States might be a political objective for some Petitioners, it would be a late moment in the history of the Republic to discover that the Constitution requires it.

Petitioners stake their entire coercion case on a single claim: that the federal government is making an offer the States cannot refuse, holding the *existing* Medicaid program hostage unless the States agree to mandatory Medicaid expansions. States' Br. 8-9, 39-42. But Petitioners do not – and cannot – point to any textual support in the ACA for their contention: each proffered text is either indistinguishable from many prior Medicaid amendments, relies on a distinction that entails no constitutional significance, or is simply misinterpreted. Furthermore, while the States claim the threatened loss of all Medicaid funding, States' Br. 10-11, 39-40, this result is anything but a foregone conclusion. Rather, any denial of federal funding rests in the reasonable discretion of the Secretary, who has *never* withdrawn all Medicaid funding for State noncompliance.

Nor should the number of Petitioners now opposed to the ACA impress this Court. Political differences over health reform policy do not equate to unconstitutional coercion of States by Congress. Or as fourth circuit judge J. Harvie Wilkinson III puts it, "[o]ur [judicial] self-control will be put to the test. The health care reform act of 2010 seems misconceived in many ways, but flawed legislation is not on that account unconstitutional." J. Harvie Wilkinson III, Cosmic Constitutional Theory: Why Americans Are Losing Their Inalienable Right to Self-Governance (in press, 2012).

ARGUMENT

I. Congress Has Exercised Its Spending Power in a Clearly Constitutional Manner

A. The Medicaid Amendments Satisfy Existing Precedent

The Court's Spending Clause jurisprudence clearly authorizes Congress to expand Medicaid to cover low-income children and adults, and this case does not compel reconsideration of well-established precedent. Bedrock cases defining the federal spending power allow Congress to offer financial incentives to States willing to participate in federal programs and policies. States are free to refuse federal conditional funding and exercise their fiscal and administrative autonomy through their own ability to tax and spend. Petitioners are unable to cite any Supreme Court precedent supporting their arguments that the Act's Medicaid amendments violate this Court's previously recognized limits on the spending power or unconstitutionally coerce States, as evidenced by their request that the Court "fashion" limits. States' Br. 28; U.S. CONST., Art. I, § 8, cl. 1.

Precedent undergirding the Medicaid program's essential design is long-standing, unambiguous, and undisturbed. Since 1936, the Court has endorsed the general welfare clause as a separate enumerated power and has recognized Congress's authority to place conditions on both taxing and spending to influence state policy. See *United States v. Butler*, 297 U.S. 1, 66 (1936); *Steward Machine Co. v. Davis*, 301

U.S. 548, 591 (1937); see also *Helvering v. Davis*, 301 U.S. 619, 644-645 (1937). Congress relied on these precedents when amending the Social Security Act in 1965 to create Medicaid.

Two recent cases have explored limits on federal conditional spending power, and neither compels a different result for the Medicaid issue before the Court. First, in *South Dakota v. Dole*, 483 U.S. 203 (1987), the Court relied on the established reasoning in *Helvering*, *Steward Machine*, and *Butler* to set forth a four-part test for conditional spending, *id*. at 207-208. In the present case, the court of appeals noted that "[t]he state plaintiffs do not contend that the Act's Medicaid expansion violates any of these restrictions" under *Dole*. *Florida v. HHS*, 648 F.3d 1235, 1263 (11th Cir. 2011); Gov't Br. 15-16.

Dole also rejected South Dakota's push for a Tenth Amendment limitation on conditional spending, tracking the reasoning advanced by the federal government. See Brief for the United States, *Dole*, 483 U.S. 203 (No. 86-260), 1987 WL 880322, at *15-16; *cf.* Brief for South Dakota, *Dole*, 483 U.S. 203 (No. 86-260), 1987 WL 880315 at *63-71. The Court expressly rejected South Dakota's argument that the Tenth Amendment places an independent constitutional bar on conditional spending. *Dole,* 483 U.S. at 210.

The Court also noted: "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as

to pass the point at which 'pressure turns into compulsion.'" *Id*. at 211 (quoting *Steward Machine,* 301 U.S. at 589-590). Upon this language, Petitioners hang all their hopes. Yet *Dole* provided no elaboration and did not find coercion on the facts of that case. Although *Dole* and *Steward Machine* acknowledged the theoretical possibility of a coercion claim, those statements have never been uncoupled from the Court's skepticism that coercion "can ever be applied with fitness to the relations between state and nation," *Steward Machine*, 301 U.S. at 590. As discussed in the Statement and in Section II, *infra,* these particular Medicaid amendments do not create enough "pressure" to become "compulsion." *Dole*, at 211 (quoting *Steward Machine,* 301 U.S. at 589-590).

The second decision to explore conditional spending power and reject Tenth Amendment limitations was *New York v. United States*, 505 U.S. 144 (1992), decided a few years after *Dole*. *New York* permitted conditional spending to "influence a State's legislative choices." *Id.* at 167, 188. Congress may "encourage a state to conform to federal policy choices" by virtue of conditional spending, and if a State's residents do not like the federal policy, they can instruct the State's legislators to reject the federal funding. *Id.* at 168. The litigants again invited judicial enforcement of Tenth Amendment limits on all congressional authority, but the Court declined the invitation and reiterated that "the Federal Government [can] hold out incentives to the States as a means of encouraging them to adopt suggested regulatory schemes." *Id*.

at 188; see also *College Savings Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999) (describing federal spending as a "gift"). The Court has never recognized the Tenth Amendment as a separate limit on the conditional spending power, and the almost fully-funded Medicaid expansion at issue is not the occasion to do so.

Finally, the Court has consistently required that States "clearly understand" the terms of the federal funding, protecting them from unknown terms. *Arlington Central School Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). In the present case, the Medicaid expansions were debated for many months and included a phase-in period of almost four years for States to assess the terms of the funding, more than sufficient for "clear notice." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 25 (1981).

B. The Reasoning of the Court of Appeals Below Is Sound and Is Further Supported By Five Additional Arguments

These Medicaid amendments are not the compelling case for creating new precedent that the States depict them to be, and not just for the reasons articulated by the court of appeals below. See *Florida v. HHS*, 648 F.3d at 1267-1268. At least five additional arguments support the Act's constitutionality.

First, the federal government has for many decades used Medicaid as a tool to further larger, national health policy goals. Congress has mandated

the fundamental elements of Medicaid – the baseline requirements of who is eligible and what services they must receive – while allowing options that expand beyond the baselines. See Statement, *supra.* Mandatory Medicaid eligibility has been expanded several times, and although on each occasion States could have withdrawn from the program, nevertheless, they remain. *Arkansas Dep't of Health & Human Servs. v. Ahlborn,* 547 U.S. 268, 275 (2006) ("States are not required to participate in Medicaid, but all of them do.").

Second, while the States claim the threatened loss of all Medicaid funding, States' Br. 10-11, 39-40, this result is not automatic but rests in the reasonable discretion of the Secretary, who has *never* withdrawn all Medicaid funding for State noncompliance. See Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *Douglas v. Indep. Living Ctr. of S. California, Inc.*, Docket Nos. 09-958, 09-1158, and 10-283, 7-8, 23-25 (2011). HHS policy is to work with States to encourage compliance rather than to penalize fragile Medicaid beneficiaries. See 42 C.F.R. 430.32 (States found to be out of compliance with federal requirements will be asked to "correct" divergent practices); 42 C.F.R. 430.35 (State funding will not be withheld until "a reasonable effort has been made to resolve the issues through conferences and discussions"). The Medicaid Act provides that "the Secretary shall notify [the] State agency that further payments will not be made to the State (*or, in his discretion, that payments will be limited to categories*

under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. 1396c (emphasis added); 42 C.F.R. 430.35 (indicating that HHS will resume any funding that was halted once compliance is demonstrated).

Petitioners' fear of total funding loss, States' Br. 35 n.15, 37, 39-40, is simply not cognizable, as the Secretary has never exercised this power in forty-seven years of Medicaid administration. The Secretary has not threatened these States with the loss of all funds after adoption of the ACA. See Gov't Br. 40-41. Coercion would surely require more than a theoretical fear of a never-expressed threat before the claim is ripe for constitutional adjudication. See, *e.g.*, *Poe v. Ullman*, 367 U.S. 497, 508 (1961) ("The fact that Connecticut has not chosen to press the enforcement of this statute deprives these controversies of the immediacy which is an indispensable condition of constitutional adjudication. This Court cannot be umpire to debates concerning harmless, empty shadows.").

Third, though Petitioners argue they are "locked" into participating in Medicaid, States' Br. 45 n.17, and it may be true that most States could not afford to run their own medical assistance programs absent changes in their tax laws, many steps lie between this argument and the conclusion that States are coerced into participating in Medicaid. The federal government does not coerce States simply because they lack the political will to leave Medicaid or to

provide funding for similar care. These arguments speak to State behavior, not federal power. Medicaid fills a need; one that the States ceded to the federal government but could take back if desired. Courts have long held that the temptation of funding does not actually remove States' "freedom of the will," *Steward Machine,* 301 U.S. at 589-590, to make a choice and live with the consequences.

Fourth, the essence of Petitioners' argument is that when States accept vast quantities of federal funds, States should gain control over federal appropriations. In short, if States depend on Medicaid, it must be coercive. If this paradox were true, then States would have a perverse incentive to maximize federal funding and their reliance upon it to such a degree that the federal government would be forced to cede control over its appropriations to the States. While unconditional block grants to States might be a political objective for some Petitioners, it is a late moment in the history of the Republic to discover that the Constitution requires it. This perverse view turns a successful model of cooperative federalism on its head and ignores the dual nature of Our Federalism, wherein both States and the United States can exercise independent powers to tax and spend.

Fifth, federal spending legislation is the law of the land by virtue of the Supremacy Clause. Telling the federal government that it cannot set the terms of its own duly enacted conditional spending statute would be a dangerous step toward reversing the

foundational, near-century-old understanding of the power to spend as a distinct enumerated power.

II. The Medicaid Amendments Are Not Coercive

Petitioners must demonstrate that whatever is wrong with Medicaid is entirely new and novel. Constitutional infirmity cannot be attached to tried and true features of the existing program. The straw that breaks the camel's back must be constitutionally distinguishable from all previous straws in Medicaid. Petitioners fail in this task.

A. Petitioners Do Not Challenge the Constitutionality of the Existing Medicaid Program

Petitioners do not claim that Medicaid itself is unconstitutional as it stood immediately before the Act. States' Br. 5; Pet'rs' Cert. Pet. 6-7. Precision is important here. Petitioners attack Medicaid with broad-brush strokes, conflating the cost of the existing Medicaid program with the new amendments. See States' Br. 39 ("The coerciveness of that demand is self-evident, as the sheer size of the federal inducement at stake puts this spending legislation in a class of one. Medicaid is already the single largest federal grant-in-aid program, accounting for a staggering 40% of all federal funds distributed to States and nearly 7% of *total* federal spending."). They make no claim that Congress's previous Medicaid amendments

are in any way constitutionally invalid. To make sense of Petitioners' coercion argument, the Court must understand that their contention is limited to very specific subsections of the new Medicaid amendments in a few portions of Title II of the Act that allegedly threaten existing Medicaid funding. States' Br. 40-41.

But the existing Medicaid program is not on trial here. If anything, Petitioners profess their reliance on existing Medicaid funding. States' Br. 39-41. The cost of the existing Medicaid program is relevant – if at all – only if the federal government actually threatens to cut off all funds in order to unconstitutionally coerce the States, which it has never done since 1965 and does not threaten to do here. See Section I.B., *supra.*

B. The Optional Medicaid Amendments Are Not Coercive

Throughout the history of the Medicaid program, some coverage expansions have been mandatory while others are completely optional for States. See Statement, *supra* (describing the history of the program). The Medicaid expansions under the Act are no different. For example, ACA Section 2001(a)(4) gives States the option to expand coverage before January 1, 2014, and ACA Section 2401 gives States the option to provide certain home and community-based services. Petitioners do not challenge any optional Medicaid amendments as coercive. See Gov't Br. 53 n.24 (citing States' Br. 47-48, 50).

C. The Mandatory Medicaid Amendments Are Not Coercive

1. The Allegedly Partisan Nature of the Act Is Not Evidence of Coercion

One of Petitioners' *amici* emphasizes the partisan nature of the ACA enactment process. Br. of Center for Constitutional Jurisprudence et al. in Support of Pet'rs (Medicaid) 13-16. Although the constitutional salience of this statement is unclear, we make a few observations.

Petitioners claim to represent twenty-six States at the present moment, States' Br. ii, but when Congress voted for the ACA in March 2010, Senators or Representatives from twenty-two of the twenty-six Petitioner States voted for the Act. Kevin Outterson, *Obama Couldn't Have Done It Without You, Red State Edition,* The Incidental Economist (February 14, 2012). From the Petitioners' congressional delegations, a total of twenty-one United States Senators and eighty-eight Members of the House of Representatives voted for the Act. *Id.* Quite simply, the Act could not have passed without the support in 2010 from the Petitioners' duly elected congressional delegations. As is often the case, the political landscape changed after the mid-term elections in November 2010,[3] but that change should alert this Court to the

[3] After the 2010 mid-term elections and after Judge Vinson had issued his substantive opinion on the motion to dismiss, 716 F. Supp. 2d 1120 (N.D. Fla. 2010), six states (Ohio, Kansas, Wyoming, Wisconsin, Maine, and Iowa) joined this suit as Petitioners

(Continued on following page)

dangerous implications of a State's *subsequent* political leadership claiming that the *former* leadership had been coerced. Shifting political winds do not imply coercion.

In addition, at least one of the Petitioners is a house divided. The Governor of Iowa is listed here as a Petitioner; meanwhile, the Attorney General of Iowa has joined two briefs in support of the Act. Br. of California et al. in Support of Resp. (Severability); Br. of Maryland et al. in Support of Pet'r (Minimum Coverage Provision). We should not assume that the Petitioners represent a monolithic consensus within their States. Politics will run their course in due time through the elected branches of our government.

2. The Mandatory Medicaid Amendments Are Not a Novel Feature of the Act

For many decades Congress has modified the Medicaid program through a combination of optional and mandatory provisions. See Statement, *supra.* Indeed, most federal spending power legislation attaches mandatory conditions to receipt of federal funds. See, *e.g.*, *South Dakota v. Dole*, 483 U.S. 203 (1987). Mandatory coverage categories are not a "transformation of Medicaid," States' Br. 38, but have been a remarkably common feature of the program for decades. See

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on January 18, 2011 through the filing of a Second Amended Complaint in the district court, N.D. Fla. Dkt. 148, despite the passing of the court's deadline for new parties to be added.

Statement, *supra* (describing mandatory Medicaid coverage categories over time). Given this historical continuity, Petitioners have failed to demonstrate why this particular set of Medicaid amendments somehow crosses a constitutionally significant line.

3. The Federal Government Bears About 95% of the Cost of the Mandatory Medicaid Amendments

The Medicaid amendments themselves are not coercive because they will cost the States little or no money. The mandatory expansions qualify for very generous federal matching (FMAP) of 100% from 2014-2016, phasing down to 90% FMAP in 2020 and thereafter. 42 U.S.C. 1396d(y). Official projections claim the Act will *save* the States $33 billion. Memorandum from Richard S. Foster, Chief Actuary, CMS, to the Obama Administration and Congress 12 (Apr. 22, 2010) ("The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling $33 billion through fiscal year 2019."); Matthew Buettgens et al., *ACA and State Governments: Consider Savings as Well as Costs*, Urban Institute (July 2011). A state-by-state analysis by The Kaiser Commission on Medicaid and the Uninsured projected that over the coming decade, the federal government will pay for 95% of the incremental costs under the Medicaid amendments, leaving 5% of the costs ($21.1 billion) to be paid by the States. John Holahan & Irene Headen, *Medicaid Coverage and*

Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL at 2 (2010).

Other cost estimates are not germane because they are not limited to the mandatory Medicaid expansions at issue in this case. For example, some cost estimates include the enrollment of previously eligible individuals, which are not new mandatory coverage expansions. See Cong. Research Service, *Variation in Analyses of PPACA's Fiscal Impact on States* (Sept. 8, 2010). Petitioners make no claim that Medicaid before the ACA was unconstitutional. Nor have they articulated any theory explaining why it is unconstitutional to encourage enrollment of people already entitled to coverage under existing law. The cost of any optional Medicaid provisions – about 60% of Medicaid costs in 2007 – is also irrelevant to this case and cannot be a basis for a coercion claim. See Gov't Br. 4, 29-30.

The fiscal impact of the mandatory coverage expansions on the States, when paired with an exceedingly generous 95% average federal match, is so modest that the Petitioners "argument as to coercion is shown to be more rhetoric than fact." *Dole*, 483 U.S. at 211. Just as the withholding of 5% of federal highway funds could not be coercive in *Dole*, the 5% State contribution to mandatory Medicaid expansion cannot be considered coercive here.

Petitioners quibble with this in only a half-hearted way. Their primary point of contention is not

with the existing Medicaid program, or the various optional and ancillary Medicaid amendments *per se*, but with the very specific provisions that allegedly threaten the loss of *existing* Medicaid funding. States' Br. 8-9, 39-42. To these arguments we now turn.

D. Petitioners Fail to Identify Any Constitutionally Infirm Text in the Mandatory Medicaid Amendments

Petitioners stake their entire coercion case on a single claim: that the federal government is making an offer the States cannot refuse, holding the *existing* Medicaid program hostage unless the States spend $21.1 billion over a decade on the mandatory Medicaid expansions. States' Br. 8-9, 39-42.

Petitioners are unaccountably vague as to the exact textual source of their troubles. See States' Br. 39 ("The ACA threatens States with loss of *all* of their federal Medicaid funding if they do not capitulate to Congress' mandate that they dramatically expand their obligations under the program."). The Petitioners offer no citation for that dramatic statement. Indeed, throughout that four-page section of their brief, no citation is made to any provision in the ACA. See States' Br. 39-42. Petitioners have yet to identify the precise language that is allegedly coercive and compels that conclusion. Petitioners obliquely suggest several candidates: (1) mandatory coverage expansion for low-income children and adults; (2) the "essential

health benefits" standard; (3) the "maintenance-of-effort" rule; and (4) Section 2304. States' Br. 7-13. As we demonstrate in the sub-sections immediately following, each proffered text is either indistinguishable from many prior Medicaid amendments, relies on a distinction that entails no constitutional significance, or is simply misinterpreted.

1. Medicaid Expansion to Low-Income Children and Adults Is Constitutional

Petitioners assert that the Act is unique in extending coverage to low-income children and adults, beginning January 1, 2014. States' Br. 6-7. This provision is found in ACA Section 2001(a)(1)(C), amending 42 U.S.C. 1396a(a)(10)(A)(i)(VIII). See Statement, *supra* (discussing this coverage expansion and its historical antecedents). Petitioners do not articulate any plausible constitutional distinction between this group of children and adults and existing Medicaid beneficiaries to whom federal law already guarantees coverage.

Medicaid presently mandates coverage for seven categories of children and nonelderly adults. 42 U.S.C. 1396a(a)(10)(A)(i)(I)-(VII); see Statement, *supra*. Petitioners articulate no reason why it is suddenly unconstitutional to adopt an eighth mandatory category of low-income children and adults under the age of 65

with incomes up to 133% FPL[4] who are not pregnant women, Medicare-eligible, or in another mandatory category. The ACA's new category becomes mandatory in 2014. In the meantime, it is an optional category that States may choose to cover. See Section II.E., *infra* (describing the efforts of early-adopter States).

Petitioners may have preferred that Congress had given this population coverage through the ACA health insurance exchanges with tax subsidies, see States' Br. 35-36, but this policy disagreement does not rise to the level of a constitutional infirmity. Congress had rational reasons for choosing Medicaid: it costs less per person than private insurance and has a long and honorable track record of serving America's poorest and most vulnerable. Whether the Petitioners agree with these reasons is the realm of politics, not constitutional law.

2. The Essential Health Benefits Provision Is Constitutional

The second textual candidate – although not clearly cited by Petitioners – is the requirement that

[4] Petitioners are concerned about the size of this Medicaid expansion, States' Br. 7-8, but do not articulate any specific constitutional infirmity with 133% FPL as a boundary, which in 2012 is an annual income of $14,856.10 for an individual in the continental United States, or $30,656.50 for a family of four. 2012 HHS Poverty Guidelines, http://aspe.hhs.gov/poverty/12 poverty.shtml. Why is 100% FPL constitutional, but 133% is allegedly not?

States provide the ACA's new mandatory category of low-income children and adults with Medicaid benchmark coverage that includes the ACA's "essential health benefits" (EHB). See ACA §2001(a)(2), amending 42 U.S.C. 1396a(k)(1); ACA §2001(c), amending 42 U.S.C. 1396u-7(b)(5); and the closely related provisions describing "benchmark" coverage, *id*. While the Petitioners label this issue "minimum essential coverage," States' Br. 8, see ACA §1302, the core definition for Medicaid purposes is EHB, from which both benchmark plans and minimum essential coverage are measured. ACA §2001(c)(3), amending 42 U.S.C. 1396u-7(b)(5). Petitioners' confusion may arise from the fact that ACA §2001(a)(2) provides for the new EHB requirement and includes the phrase "minimum essential coverage" in its caption. See ACA §2001(a)(2).

Petitioners characterize the EHB changes as novel and revolutionary. States' Br. 8 ("that new and onerous requirement . . . "). As the history of Medicaid aptly demonstrates, program design has never been static, see Statement, *supra*, and mandatory coverage standards for categorically needy individuals have been a hallmark of the program since 1965. See 42 U.S.C. 1396a(a)(10)(A). Coverage changes are an annual feature of most commercial health plans and are similarly unsurprising in Medicaid. This commonplace activity does not rise to the level of unconstitutional coercion.

While the federal government has historically and constitutionally mandated minimum Medicaid

coverage standards, the federal government has, in the case of the EHB, indicated an intention to delegate to the States authority to define the details of the EHB. Center for Consumer Information and Insurance Oversight, Department of Health and Human Services, *Essential Health Benefits Bulletin* at 8 (Dec. 16, 2011). For example, the definition of benchmark plans in the HHS guidance allows States to choose among several types of plans offered in the large group or small group markets, thus allowing the EHB package to vary from State to State, based on local commercial market factors. *Id.*; see also Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Oct. 7, 2011). Many other decisions are also being made at the State level, such as the distinction between medical and nonmedical benefits, *id.* at 4-19 to 4-20, and the definition of "medical necessity," *id.* at 5-23 to 5-28. Therefore, Petitioners' claim that the Act "eliminates the flexibility States previously enjoyed," States' Br. 8, is unfounded and overstated. Indeed, HHS policy on implementing the ACA more broadly has reflected a commitment to "maximum flexibility" to the States in implementing the Act's cooperative programs. See, *e.g.,* U.S. Dept. of Health and Human Services, *Patient Protection and Affordable Care Act, Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41866, 41893 (July 15, 2011) (announcing regulations affording State regulators "significant flexibility" in applying standards for qualified health plans under the new State Exchanges).

Petitioners are reduced to arguing that conforming Medicaid to the same coverage standard required for many commercial insurance plans under ACA §1302 is unconstitutionally coercive, while not challenging Section 1302 itself. This is thin gruel for a coercion claim, especially when States pay so little of the incremental cost.

3. The Maintenance-of-Effort Provision Is Not Coercive

Only one subsection in the Act appears to condition *existing* FMAP on immediate compliance with a provision Petitioners find objectionable: the "maintenance-of-effort" (MOE) provision in ACA §2001(b)(2), amending 42 U.S.C. 1396a(gg); States' Br. 6, 8-9, 45 n.17; Gov't Br. 30-31. As CMS explained to States, "[t]he MOE provisions in the Affordable Care Act generally ensure that States' coverage for adults under the Medicaid program remains in place pending implementation of coverage changes that become effective in January 2014." CMS, Letter to State Medicaid Directors, Re: Maintenance of Effort 1 (Feb. 25, 2011) (*MOE Letter*).

Claims of coercion or lack of clear notice are not supportable given that HHS has used MOE provisions in many previous situations. Mark Greenberg, *HHS Policy Guidance On Maintenance of Effort, Assistance, and Penalties: Summary and Discussion*, 4 Geo. J. on Fighting Poverty 315 (1997). Indeed, the "Affordable Care Act MOE statutory provisions are very similar to the MOE provisions in section

5001(f)(1) of the American Recovery and Reinvestment Act," which were in place and to which States were subject before the ACA was passed. See *MOE Letter*, at 1.

In addition, the relevant MOE provision here is temporary, expiring State by State as exchanges are created, no later than Dec. 31, 2013.[5] ACA §2001(b)(2), codified at 42 U.S.C. 1396a(gg)(1)-(2). When States have fully operational exchanges, the relevant part of the MOE provision is effectively waived. ACA §2001(b)(2).

Finally, the MOE provision cannot support a coercion argument because States may receive a waiver of the requirement through a simple process. Petitioners complain that the mandatory expansions will directly impact their budgets, States' Br. 18, 39, but ignore ACA §2001(b)(2), amending 42 U.S.C. 1396a(gg)(3), which excuses State noncompliance with the MOE with respect to non-pregnant, non-disabled adults earning more than 133% FPL if "the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect

[5] For children under 19, the MOE provision expires on October 1, 2019. Section 2001(b)(2), codified at 42 U.S.C. 1396a(gg)(2). Petitioners do not specifically challenge the children's eligibility rules, focusing their complaint at the expansion for low-income childless adults, States' Br. 7-8, so the relevant expiration date is no later than December 31, 2013.

to the succeeding year, the State is projected to have a budget deficit." *Id*; *MOE Letter*, at Q.5.

At least one Petitioner has made this certification to the Secretary. On December 29, 2011, the State of Wisconsin filed the required certification. Letter from Mike Huebsch, Secretary, Wisconsin Department of Administration (Dec. 29, 2011) (attachment). Under this certification and pending an amendment to the State plan, Wisconsin will disenroll 53,161 Wisconsin residents from Medicaid. Wisconsin Department of Health Services, *2011-2013 Medicaid Efficiencies, Maintenance of Effort (MOE) Waiver Request of Eligibility Restrictions Established Under the Patient Protection and Affordable Care Act* (PPACA) (undated, *circa* 2011). The certification excuses Wisconsin from the MOE provision until June 30, 2013, and thereafter if Wisconsin files again. *Id*.

4. Section 2304 Is a Modest Clarification, Not a Sweeping Change

As the last arrow in their quiver, Petitioners claim "the Act requires States not only to pay the costs of care and services for Medicaid enrollees, but also to assume responsibility for providing 'the care and services themselves.'" States' Br. 9. This may sound like a commandeering claim, but it is nothing of the sort. Petitioners cite ACA Section 2304, concerning "the care and services themselves," States' Br. 9, but curiously ignore the use of the disjunctive "*or*"

immediately before and "or both" immediately after their quote. The full text of Section 2304 (found not in the text, but only in their appendix, States' Br. 45a) inserts "or the care and services themselves, or both." The omitted language is significant; in fact, the omitted language entirely undermines Petitioners' ensuing argument.

The purpose of this provision was merely to clarify the long-standing meaning of "medical assistance" in Medicaid. See Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements,* 42 U.C. Davis L. Rev. 413, 453-458 (2008). The House Report makes this abundantly clear:

> Section 1905(a) of the Social Security Act defines the term "medical assistance." The term is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. The Committee, which has legislative jurisdiction over Title XIX of the Social Security Act, has always understood the term to have this combined meaning. Four decades of regulations and guidance from the program's administering agency, the Department of Health and Human Services, have presumed such an understanding and the Congress has never given contrary indications.

H.R. Rep. No. 111-299, 1st Sess., at 649-650, 2009 WL 3321420, at *693-695 (Leg. Hist.) (Oct. 14, 2009); see

also 156 Cong. Rec. H1854, 1856, 2010 WL 1006359 (Mar. 21, 2010) (statement of Rep. Waxman) (explaining on the House floor the committee report's rationale for the clarification); *id.* at H1891, 1967, 2010 WL 1027566 (Mar. 21, 2010); Jane Perkins & Gene Coffey, *Patient Protection Act Clarifies The Meaning of "Medical Assistance,"* National Health Law Program (March 31, 2010) (discussing the cases and legislative history). This modest clarification does not require any State to provide medical services directly.

E. The Medicaid Amendments Cannot Be Considered Coercive to Early Adopter States

ACA §2001(a)(4) allows "early adopter" States to voluntarily expand coverage prior to January 1, 2014. Minnesota, Connecticut, and Washington D.C. have taken advantage of this provision and other States, such as Massachusetts and California, have essentially become early adopters through Medicaid waivers.

The example of early adopter States advances two arguments. First, the fact that some States have eagerly expanded optional coverage years ahead of schedule undermines Petitioners' claim of coercion. Clearly, these States, and other States filing briefs supporting the Act, embrace the Medicaid amendments.

Second, States accepting these benefits should be protected from any ruling that would strike down

relevant portions of the Medicaid amendments. The Petitioners, if successful on this issue, seek the freedom to reject the federal offer, but this remedy should not be imposed on other States that willingly accept the Medicaid amendments. The more appropriate remedy "would be to enjoin the 'application' of the provision to unconsenting States and otherwise to permit the eligibility extension to function as written." Gov't Br. 53 (citation omitted). Any State that wants to continue to access federal funds under the ACA should be allowed to do so, whether or not a sister State alleges coercion. Federalism is not well served by destroying the carefully crafted laws and programs that many States have built in reasonable reliance on the ACA, including the exchanges and accepting the offer of early optional expansion. Br. of California et al. in Support of Resp. (Severability), 13-27 (detailing the legislative efforts of California and other States to implement the ACA).

Connecticut was the first state to take advantage of the early adoption provision. *Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act*, U.S. Department of Health & Human Services (June 21, 2010). Connecticut expected that 45,000 adults would become Medicaid-eligible under the new expansion. *Id.*

In May 2010, the District of Columbia followed suit. Darryl Fears, *D.C. Jumps At Health-Care Savings In Expanded Medicaid*, Wash. Post, May 14, 2010, at B2. The approval of the request of the District of Columbia for the early enactment of the

Medicaid expansion meant "switch[ing] 35,000 individuals from an insurance program funded by city taxpayers to the Medicaid program." *Id.*

In January 2011, Minnesota expanded the state's Medical Assistance Program, "provid[ing] MA benefits for an estimated 51,000 adults currently enrolled in MinnesotaCare and approximately 12,000 people not enrolled in a state health care program." *Governor Dayton Expedites Medicaid Expansion*, Home Page of the Office of the Governor (Jan. 20, 2011).

Under a Medicaid Section 1115 waiver, Massachusetts has already expanded subsidized insurance coverage to the population between 100% and 133% of the FPL. Br. of Health Care For All et al. (Minimum Coverage Provision) 7. Coverage has been extended to 411,722 Massachusetts residents under its reforms. *Id.* at 9. Absent the additional federal funding through this waiver, Massachusetts could not continue its Chapter 58 health care reform initiative. *Id*. at 7. Massachusetts and CMS recently agreed on a $26.75 billion extension of this waiver for the next three years. *Governor Patrick Announces $26.75 Billion Medicaid Waiver Agreement* (Dec. 21, 2011).

California also was granted a Medicaid waiver to allow the State to transition to Medicaid expansion to take place in 2014 under the Act. California Department of Healthcare Services, *California Bridge to Reform: A Section 1115 Waiver Fact Sheet* (Nov. 2010). Though not utilizing provisions in the ACA itself, the waiver expands coverage to those individuals who

will be newly eligible under the Medicaid expansion in 2014. *Id.* California has nearly seven million uninsured individuals and roughly a fifth of those individuals are expected to be covered by 2016 under the program. Kaiser Family Foundation, *California's "Bridge To Reform" Medicaid Demonstration Waiver* (Oct. 2011 Update). As with Massachusetts, California is heavily relying on these Medicaid expansions to ensure that it can afford to provide healthcare for its residents. Br. for California et al. in Support of Resp. (Severability) 28 ("Hundreds of thousands of individuals could thus face losing their health insurance.").

The clearly expressed desire of these early adopter States, which are eager to accept the federal offer to help hundreds of thousands of State residents, demonstrates that Petitioners' fear of coercion is not universally felt amongst the States. In no event should the reasonable expectations of these States, including enhanced FMAP for mandatory and optional coverage expansions, be upset by the inchoate fears of their sister States.

CONCLUSION

The judgment of the court of appeals upholding the Medicaid eligibility expansion should be affirmed.

Respectfully submitted,

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