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 U.S. Court of Appeals for the Eleventh Circuit

BRIEF OF SENATE MAJORITY LEADER HARRY REID, HOUSE DEMOCRATIC LEADER NANCY PELOSI, AND CONGRESSIONAL LEADERS AND LEADERS OF COMMITTEES OF RELEVANT JURISDICTION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (Medicaid)

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INTEREST OF *AMICI CURIAE*[1]

Amici are Senate Majority Leader Harry Reid, House Democratic Leader Nancy Pelosi, and the following congressional leaders and leaders of the relevant committees of jurisdiction:

Sen. Dick Durbin (Assistant Majority Leader)	Rep. Steny H. Hoyer (Democratic Whip)
Sen. Charles Schumer (Conference Vice Chair)	Rep. James E. Clyburn (Democratic Assistant Leader)
Sen. Patty Murray (Conference Secretary)	Rep. John B. Larson (Chair of Democratic Caucus)
Sen. Max Baucus (Chair, Committee on Finance)	Rep. Xavier Becerra (Vice Chair of Democratic Caucus)
Sen. Tom Harkin (Chair, Committee on Health, Education, Labor, and Pensions)	Rep. John D. Dingell (Lead Sponsor of House Health Care reform legislation)
Sen. Patrick Leahy (Chair, Committee on the Judiciary)	Rep. Henry A. Waxman (Ranking Member, Committee on Energy and Commerce)

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[1] Counsel for all parties have consented to the filing of *amicus* briefs, and their consents are reflected on the docket. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or its counsel made a monetary contribution to its preparation or submission.

Sen. John D. Rockefeller IV (Chair, Committee on Commerce)	Rep. Frank Pallone, Jr. (Ranking Member, Energy and Commerce Subcommittee on Health)
Rep. Fortney Pete Stark (Ranking Member, Ways and Means Subcommittee on Health)	Rep. Sander M. Levin (Ranking Member, Committee on Ways and Means)
Rep. Robert E. Andrews (Ranking Member, Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions)	Rep. George Miller (Ranking Member, Education and the Workforce Committee)
Rep. Jerrold Nadler (Ranking Member, Judiciary Subcommittee on Constitution)	Rep. John Conyers, Jr. (Ranking Member, Committee on the Judiciary)

Amici file this brief for two reasons. First, as elected Members of Congress, *amici* have a duty to support the Constitution, and in exercise of that duty, they write to defend the constitutionality of the Patient Protection and Affordable Care Act. The Act is a landmark accomplishment of the national Legislature, which brings to fruition a decades-long effort to guarantee comprehensive, affordable, and secure healthcare insurance for all Americans. *Amici* paid careful attention to Supreme Court precedents defining the proper bounds of Congress's constitutional authority and relied upon these established rules in formulating, debating, and voting on the Act. They wish to put before the Court

their views on why the Act is a valid exercise of Congress's Article I powers.

Second, *amici* believe that the legal theories advanced by the Act's challengers, if embraced by the courts, would seriously undermine Congress's constitutional authority and its practical ability to address pressing national problems. Congress regularly relies on its enumerated powers to protect American consumers and workers, to keep families safe, and to ensure civil rights. *Amici* take seriously their oath to "support and defend the Constitution of the United States," and write in their constitutional role as Members of a coequal branch of government.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress enacted the Patient Protection and Affordable Care Act ("the Act" or "ACA") in response to a national crisis—over 50 million Americans are currently without healthcare insurance. Congress believed that without a policy response at the federal level, this crisis would only deepen.

But, of course, opinions diverged sharply both within Congress and across the country about the precise nature of the proper policy response to this problem. The process of enacting the ACA reflected those disagreements. For fourteen months, Congress debated, refined, revised, and debated again the ACA and the policy judgments that it embodies. In the end, however, the ACA was adopted by a majority of the House of Representatives and a supermajority of the Senate, and was signed by the President. The opponents of the congressional policies embodied in the ACA now ask this Court to reverse the result of

the democratic process and put the nation back on a path toward an ever-growing number of uninsured Americans.

A major policy judgment made by Congress in passing the Act was that Medicaid should be part of the solution to the crisis of the uninsured. For forty-five years, the nation has relied on Medicaid to provide coverage for healthcare and long-term-care services to low-income Americans. Through the Medicaid program, Congress has made available billions of dollars in financial assistance to the States that choose to participate, while conditioning receipt of those funds on compliance with certain requirements regarding eligibility, benefits, provider payment, and administration. Within those requirements, participating States have substantial discretion to design and administer their programs. Congress has also given participating States the ability to cover certain optional populations and offer certain optional benefits with the assistance of federal funds. This programmatic flexibility has resulted in considerable variation in Medicaid programs from State to State.

More specifically, while preserving many choices open to the States, the ACA expands Medicaid eligibility by requiring that the States extend benefits to individuals under the age of 65 with incomes below 133 percent of the federal poverty level. ACA § 2001(a)(1). Medicaid currently extends eligibility to many but not all groups of people below this income threshold, and an estimated 16 million additional Americans will qualify for Medicaid as a result of the ACA's expansion. Congress also specified that a certain level of medical care and

services must be offered, *i.e.*, a "benchmark" plan with at least the essential health benefits required of plans to be sold in individual and small-group insurance markets. *Id.* § 2001(a)(2).

Significantly, unlike past Medicaid expansions—where the federal medical assistance percentage for some States was as low as 50 percent—the federal government will reimburse many States for 100 percent of the costs of the benefits paid on behalf of those made eligible by the ACA from their effective date in 2014 through 2016. *Id.* § 2001(a)(3)(B); Health Care and Education Reconciliation Act of 2010 ("HCERA") § 1201.[2] That percentage will gradually decrease—to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019—and eventually level off for all States at 90 percent in perpetuity. ACA § 2001(a)(3)(B). These percentages have almost no precedent in Medicaid policy; the costs of services to almost all currently eligible populations are matched at an average rate of 57 percent. Andy Schneider and David Rousseau, *Medicaid Resource Book* ch. III at 82 (Kaiser Commission on Medicaid and the Uninsured July 2002).[3]

One fundamental aspect of Medicaid that Congress did *not* change in adopting the ACA is that State participation in the program remains, as it has

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[2] Certain States that expanded Medicaid coverage to this population prior to the enactment of the ACA will receive less than the 100 percent federal match in the initial years but will receive the 90 percent match in the long run. *See* 42 U.S.C. § 1396d(z).

[3] *Available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=14261.

always been, entirely voluntary. Provider participation and individual participation in the program likewise remain entirely voluntary.

Notwithstanding the voluntary nature of Medicaid, Congress expected that all of the States would choose to continue participating in the program under the ACA. The problems posed by an enormous population of uninsured individuals affect state and local governments acutely—for example, state and local governments often bear much of the financial burden of uncompensated care. And because the federal government ultimately will reimburse 90 percent of the costs of benefits paid on behalf of beneficiaries newly eligible under the ACA, the Act offers the States a way to address the growing crisis of uninsured citizens while bearing only a relatively small percentage of the cost. Therefore, Congress anticipated that the States would continue to participate in Medicaid because of the tremendous fiscal advantages that the program confers upon them.

Indeed, credible projections indicate that the Medicaid expansion will, on balance, *help* state budgets because any increase in state spending under Medicaid will be more than offset by new savings under the Act. Those savings will include savings on (1) state-funded programs serving people who will be newly Medicaid-eligible; (2) state-funded programs for those who will be eligible for subsidized coverage on the healthcare exchanges established by the Act; (3) state-funded high-risk pools whose beneficiaries will become eligible for coverage through the exchanges; and (4) premiums paid by state and local employers for group health coverage

for their employees, on account of reduced cost-shifting of the costs of uncompensated care to group health plans.

In passing the ACA, Congress was well aware that the political leadership in some States objects to healthcare reform as a policy matter, and specifically to using Medicaid to expand coverage. Through the legislative process, Congress heard those States' objections loud and clear—and repeatedly. But in the end, Congress rejected them while accommodating the States' fiscal concerns with unprecedentedly generous federal funding for the newly eligible population. And, of course, as previously noted, while Congress *expected* that the States would remain in the Medicaid program because of its fiscal advantages, Congress did not *require* such participation, but rather retained the bedrock principle of voluntary state participation.

In debating and ultimately adopting the ACA, Congress had no reason to expect that anything in the Constitution barred elected federal officials from making a policy judgment to expand coverage under Medicaid—which Congress had previously expanded repeatedly over the years. Indeed, even the challengers do not dispute that as a general matter Congress may, under the Spending Clause, "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 also may "condition[] receipt of federal moneys upon compliance ... with federal statutory and administrative directives," *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). Nor do the challengers dispute that the Act's amendments to Medicaid satisfy the four well established restrictions on

Congress's spending power set forth by this Court in *Dole*. *See id.* at 207-10. Instead, the challengers' novel "coercion" theory—*never* previously applied by *any* court to invalidate an act of Congress—depends entirely on the claim that even though the States' participation in Medicaid remains entirely voluntary under the ACA, in practice they have no choice but to participate.

This Court should reject the challengers' arguments for multiple reasons. First, it would be a mistake even to accept the existence of a so-called "coercion doctrine." Such a doctrine would necessarily drag federal judges into policy debates that ought not be addressed in litigation because attempting to draw a line between permissible persuasion and impermissible coercion would inevitably raise political questions that ought not be resolved by the courts. Relatedly, even attempting to make such distinctions would require the courts to resolve intractable factual questions that vary from State to State as a result of different policy choices made by different state governments about how much healthcare to provide and how to pay for it. And a court-enforced coercion doctrine would also usurp Congress's core role as the entity elected by citizens to make difficult policy decisions. For these reasons, *amici* urge the Court, as a threshold matter, to decline to adopt a "coercion doctrine."

Second, even if the Court accepts some version of a "coercion doctrine," it should not adopt any form of the doctrine that would support the challengers' claim here. The challengers are factually incorrect that the States have "no choice" but to remain with the Medicaid program, and logically incorrect that

Congress's failure to provide for the eventuality that a State might drop out means that Congress understood the States to have no choice. In reality, what Congress understood is that a program whereby the States can address the health-insurance needs of their poorest citizens with a State's expenditures ultimately limited to 10 percent of the total cost of such coverage, is such a good deal that the States are exceedingly unlikely to turn it down. But again, they are certainly entitled to do so if they wish—Medicaid participation remains completely voluntary.

Finally, accepting the challengers' coercion arguments here could have far-reaching unintended consequences. A decision in the challengers' favor might, for example, call into question prior expansions of healthcare coverage through the Medicaid program. It might also call into question other federal programs, because Congress routinely conditions the receipt of federal funding on the States' agreement to fulfill congressional requirements. And such a decision would make it difficult for Congress to legislate going forward, while also harming the States by making Congress less able to adopt programs that would provide financial assistance to the States.

ARGUMENT

I. THE COURT SHOULD NOT ADOPT ANY FORM OF A COERCION DOCTRINE.

The heart of the challengers' objection to the ACA's expansion of Medicaid is that it allegedly exceeds Congress's power under the Spending Clause because "Congress may not exercise its spending

power coercively." Pet. Br. 29. But the challengers do not even attempt to articulate a standard that would allow the courts to distinguish impermissible coercion from permissible persuasion; to the contrary, they acknowledge that "the line between coercion and persuasion" is not "bright." *Id.* at 30.

While correct so far as it goes, that concession is a dramatic understatement. As discussed below, requiring the federal courts to attempt to distinguish between persuasion and coercion in the context of the spending power would be unworkable. But, for fundamental reasons, it would also be undesirable. First, the challengers' arguments would drag the judiciary into a thicket of political judgments and quasi-factual determinations that are not suitable for resolution through litigation. And the challengers' approach would simultaneously take those decisions *away* from the officials who are elected to make them. These problems strongly counsel against enshrining a coercion doctrine in the law.

A. The Challengers' Coercion Arguments Lack Judicially Administrable Standards and Raise Fundamentally Political Issues.

In assessing the challengers' arguments, it is important to recognize that there are four judicially enforceable limitations on Congress's spending power. First, those conditions must promote the general welfare. *Dole*, 483 U.S. at 207. Second, conditions on receipt of federal funds must be reasonably related to the legislation's stated goal. *Id.* Third, such conditions must reflect Congress's unambiguous intent to condition funds on a particular action by the States as to which they may

knowingly choose. *Id.* And finally, conditions on federal funds may not violate other provisions of the Constitution. *Id.* As the Eleventh Circuit found, the challengers "do not contend the Act's Medicaid expansion violates any of these restrictions." Pet. App. 53a.[4]

1. *Steward Machine* and *Dole* did not establish a coercion doctrine.

Rather than relying on these long-standing limitations, the challengers incorrectly argue that this Court "has long recognized that an exercise of Congress' spending power would violate the Constitution if it were 'so coercive as to pass the point at which "pressure turns into compulsion."'" Pet. Br. 27 (quoting *Dole*, 483 U.S. at 211, in turn quoting *Steward Machine v. Davis*, 301 U.S. 548, 590 (1937)). But the challengers dramatically overread *Dole* and *Steward Machine*, which do no more than allude to the *possibility* that legislation could conceivably be so coercive as to be constitutionally impermissible. And the challengers do not even attempt to articulate judicially enforceable standards for a coercion test, essentially conceding that such an analysis would be an inherently political one.

The decisions of this Court upon which the challengers rely reflect concerns about both the judicial administrability of a coercion doctrine and its inherently political nature. Indeed, the opinion of the Court in *Steward Machine*—in which this Court

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[4] All citations to the Petitioner's Appendix are to the appendix to the federal government's petition for certiorari in *U.S. Department of Health and Human Services v. Florida*, No. 11-398.

first suggested (in a single sentence) the possibility of a coercion analysis—carefully prefaced that suggestion with the caveat "*if we assume* that such a concept can ever be applied with fitness to the relations between state and nation." 301 U.S. at 590 (emphasis added). *Steward Machine* also expressly cautioned that entrusting the courts to police the line between "pressure" and "coercion" might be unmanageable. This Court correctly observed that every federal spending statute "is in some measure a temptation," and "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Id.* at 589-90.

The D.C. Circuit examined this language of *Steward Machine* more than thirty years ago in a case—like this one—questioning new funding conditions imposed by amendments to Medicaid. *See Oklahoma v. Schweiker*, 655 F.2d 401 (D.C. Cir. 1981). *Schweiker* understood *Steward Machine* as "admonish[ing]" that "courts should attempt to avoid becoming entangled in ascertaining the point at which federal inducement to comply with a condition becomes a compulsion." 655 F.2d at 413. The D.C. Circuit further observed that Justice Cardozo's opinion "wis[ely]" recognized that "[t]he courts are not suited to evaluating whether the states are faced ... with an offer they cannot refuse or merely a hard choice." *Id.* at 414. There is, in short, nothing in *Steward Machine* to support the challengers' claim that this Court "has long recognized" a coercion doctrine. Pet. Br. 27.

Nor does the challengers' coercion theory find support in this Court's decision in *Dole*. Quoting *Steward Machine*, the *Dole* Court did note 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.'" *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590) (emphasis added). But *Dole* also quoted *Steward Machine*'s warning that every federal spending statute is in "some measure a temptation" and that equating motive or temptation with "coercion [would] plunge the law into endless difficulties." 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 589-90). *Dole* thus goes no further than *Steward Machine* toward adopting a coercion doctrine that this Court has acknowledged would likely defy judicial administration.

2. A coercion doctrine would be standardless and unworkable.

As courts and commentators have observed, developing enforceable coercion standards would be difficult or impossible. Professor Chemerinsky stated bluntly: "The Court ... should not attempt to enforce such a [coercion] limit on the spending power." *Protecting the Spending Power*, 4 Chap. L. Rev. 89, 102 (2001) ("*Spending Power*"). He explained that it is "impossible to draw a line between inducement and compulsion," and that "[a]ll conditions on financial aid from Congress to the states are meant to be an inducement." *Id.* Moreover, employing the term "coercion" in the way the challengers do here "obscures the distinction between a difficult choice and compulsion." *Id.* at 103. Professor Chemerinsky concluded that the States "may have to make a hard decision in foregoing federal funds," but under the "spending power ... states always retain a choice,

unpleasant as it may be to give up the federal funds." *Id.*

Professor Sullivan's careful analysis in *Unconstitutional Conditions*, 102 Harv. L. Rev. 1413, 1428 (1989), explained *why* it is "impossible to draw a line between inducement and coercion." *Spending Power*, 4 Chap. L. Rev. at 102. According to Professor Sullivan, *any* attempt to reduce "coercion" to an empirical account is logically doomed to fail because *any* conception of coercion is "irreducibly normative." 102 Harv. L. Rev. at 1428. At root, "[c]oercion is a judgment" about whether potential beneficiaries of federal spending are, as a result of the conditions attached, "worse off with respect to a benefit than they *ought* to be." *Id.* at 1450 (emphasis in original). The clear implication of Professor Sullivan's argument is that allowing—to say nothing of requiring—the judiciary to make judgments about whether States are worse off than they *ought* to be as a result of conditions on federal benefits invites judges to make political decisions.

The Ninth Circuit's decision in *Nevada v. Skinner*, 884 F.2d 445 (9th Cir. 1989), explored in detail the difficulty of establishing standards for judicial enforcement of a coercion test. Nevada argued that withholding all federal highway funds—approximately 95 percent of the State's total highway budget—from the State for failure to comply with the federal speed limit violated a purported "coercion" limitation on Congress's spending power. The Ninth Circuit noted that Nevada had "not given us any principled definition" of the term "coercion," and "our own inquiry has left us with only a series of unanswered questions." *Id.* at 448.

Some of those questions, the Ninth Circuit found, concern how heavily to weigh the loss of federal funds in a coercion analysis:

> Does the relevant inquiry turn on how high a percentage of the total programmatic funds is lost when federal aid is cut-off? Or does it turn ... on what percentage of the federal share is withheld? Or on what percentage of the state's total income would be required to replace those funds? Or on the extent to which alternative private, state, or federal sources of ... funding are available?

Id. And other questions, the court continued, are even "more fundamental" because they involve how to weigh the States' own choices as sovereign entities in the analysis:

> [S]hould the fact that Nevada, unlike most states, fails to impose a state income tax on its residents play a part in our analysis? Or, to put the question more basically, can a sovereign state which is always free to increase its tax revenues ever be coerced by the withholding of federal funds—or is the state merely presented with hard political choices?

Id.

The Ninth Circuit concluded that a coercion doctrine would be "highly suspect as a method for resolving disputes between federal and state governments" given the "difficulty if not impropriety of making judicial judgments regarding a state's financial capabilities." *Id.*

The Ninth Circuit also correctly found support for its rejection of a coercion doctrine in this Court's decision in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985). Although *Garcia* was not a Spending Clause case, it arose in a related Tenth Amendment context and strongly suggests that rules or doctrines purporting to require federal judges to draw Tenth Amendment lines that simply cannot be drawn with any intellectual consistency—such as what government functions are "traditional" or integral"—should be rejected. The Court in *Garcia* also concluded that, under the Commerce Clause, the "fundamental limitation that the constitutional scheme imposes ... to protect the 'States as States'" inheres "in the workings of the National Government itself." *Id.* at 552-54.

The same should be true here. Rather than require courts to make political choices, reliance should be placed on the safeguards built into our federal system, such as the States' "indirect influence over the House of Representatives and the Presidency by their control of electoral qualifications and their role in Presidential elections," and their "more direct influence in the Senate, where each State received equal representation," which is "underscored by the prohibition of any constitutional amendment divesting a State of equal representation without the State's consent." *Id.* at 551. "In short," the *Garcia* Court concluded, "State sovereign interests … are more properly protected by procedural safeguards inherent in the structure of the federal system than by judicially created limitations on federal power." *Id.* at 552.

B. A Coercion Doctrine Would Require the Courts to Resolve Difficult Policy Questions.

The problems with judicial administration of a coercion doctrine go beyond the impracticality (or impossibility) of drawing a principled line between persuasion and coercion. The kinds of questions identified by the Ninth Circuit in *Nevada v. Skinner*, *see supra* at I.A.2., implicate specific factual inquiries—*e.g.,* the size of the federal grant at issue, the percentage of the state program represented by those federal funds, and the percentage of state revenues that the federal grant represents. The answers to these questions will be different for different States. In other words, as the D.C. Circuit pointed out in *Schweiker*, in connection with a nationwide program like Medicaid "[e]ven a rough assessment of the degree of temptation [versus coercion] would require extensive and complex factual inquiries on a state-by-state basis." *Schweiker*, 655 F.2d at 414. This could lead to bizarre holdings that the same law was unconstitutionally coercive in some States but not others.

Using the three factors identified in the paragraph above as examples, the government pointed out the wide state-by-state variations to the Florida district court:

> With respect to the first [factor], in fiscal year 2008, federal Medicaid grants ranged from $246 million (Wyoming) to $23.8 billion (New York)—nearly a 100-fold difference.... [With respect to the second] ... the proportion of state Medicaid

> expenditures funded by federal dollars ranged from 50 percent (several states, including Colorado) to 76 percent (Mississippi).... And third, state spending on Medicaid, as a proportion of total state revenues, ranged from 8.4 percent (Alaska) to 34.5 percent (Missouri)—meaning that the proportion of total state revenues formed by federal Medicaid grants ranged from 4.4 percent (Alaska) to 21.5 percent (Missouri).

Memorandum in Support of Defendants' Motion for Summary Judgment, Docket. No. 82, at 45 (Nov. 4, 2010) ("Gov't Mem. re SJ"). As the government concluded, "the benefits and obligations of Medicaid participation affect states in quite different ways," and thus "a conditional spending program might be 'coercive' to one state, but not to another—its fate hanging only on which state chose to sue." *Id.*

Moreover, the different factual situations in different States *result* from different policy choices made by the States about how much healthcare to provide and how to fund those services. Not only have certain States elected to spend more than others on Medicaid, but, of course, different States make different policy choices about how much to spend on everything from education to prisons. And different States fund their state expenditures (including healthcare) differently. For example, six of the States in the challenger group have no personal income tax. That may be sound policy, but it does raise doubts about whether "a sovereign state which is always free to increase its tax revenues [can] ever be coerced by the withholding of federal funds."

Nevada, 884 F.2d at 448. Clearly, then, taking the results of detailed, state-specific factual inquiries and balancing whether the benefits of a federal grant are outweighed by the strings attached would lead the courts into "questions of policy and politics that range beyond [the courts'] normal expertise." *Id*.

In sum, the question whether a State can—as a practical matter, given the particular background facts specific to that State—refuse federal funding quickly becomes a classic political question that hinges on policy priorities of elected state officials and the views of its electorate. *Amici* urge that the federal courts should not be in the business of making such evaluations.

II. UNDER A COERCION ANALYSIS, THE REQUIREMENTS AT ISSUE ARE WELL WITHIN CONGRESS'S POWER UNDER THE SPENDING CLAUSE.

Putting aside the inherent problems with judicial administration of any form of a coercion doctrine, the ACA should not be invalid under any reasonable form of a coercion doctrine that might be adopted.

A. The ACA Does Not Change the Basic Structure of Medicaid Funding, Which Has Never Been Found to Be Coercive.

Congress has always required States that wish to participate in Medicaid to adopt state Medicaid plans that comply with numerous conditions set by Congress. Among these conditions, States have always been required to cover certain categories of Americans, and they have always had to cover certain minimum medical services. *See* 42 U.S.C. § 1396a. If a State fails to adopt such a plan, it has

always been ineligible for Medicaid funding, *see id.* §1396b(a), and if it changes its plan or fails to amend its plan to meet new federal conditions, the federal government has always retained discretion to cut off either some or all of that State's Medicaid funding. *See id.* § 1396c; 42 C.F.R. § 430.12(c)(1)(i).

The ACA does not change this basic structure; it simply adds to the already long list of what must be included in a State's Medicaid plan. *See* ACA § 2001(a) (amending 42 U.S.C. § 1396a). To the already long list of groups that must be covered under a State's Medicaid program, the amendment adds another group: nonelderly adults with income at or below 133 percent of the poverty line who were not already covered. ACA § 2001(a). These new conditions are analytically indistinguishable from the conditions previously contained in Section 1396a.

Nor is this the first time that Congress has chosen to expand the conditions of Medicaid participation. *See* 42 U.S.C. § 1396a Notes (listing numerous amendments). Congress has repeatedly amended the conditions of Medicaid participation—often by changing coverage that had been provided voluntarily by the States into minimum conditions of participation. *See infra* § III.A; John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Financing Review 105, 108 (Fall 2000) ("*Medicaid Spending*") (Congress embarked on "a series of Medicaid expansions" that "affected nearly the entire spectrum of Medicaid enrollees." Although these expansions were initially voluntary, "most of the options were converted by subsequent legislation into mandates."). Moreover, no court has ever found

one of Congress's prior Medicaid funding conditions to be coercive.

The challengers assert that the ACA is different from prior Medicaid expansions because Medicaid has grown larger over time. Pet. Br. 23. But merely pointing out that the States conditionally receive large amounts of money through Medicaid does not show that participation in the program is coerced. Were this true, *every* condition listed in 42 U.S.C. § 1396a—not merely those added by the ACA—would be coercive. Indeed, such a vast view of coercion would mean that once a federal grant program becomes large enough, Congress could *never* impose conditions on participation in the program.

Not surprisingly, the challengers' expansive view of coercion is not consistent with the decisions of the lower courts, which have repeatedly emphasized that the sorts of garden-variety funding conditions at issue here are not coercive. The challengers characterize the conditions imposed on Medicaid funding as coercive simply because refusing Medicaid funds would strain state budgets and force state legislators to make difficult decisions. But the courts of appeals have consistently held that conditions on federal funding are not coercive simply because they impose "politically painful" choices, *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000), or because a State's decision to decline federal funding would have "fiscal and possibly political ramifications for state officials," *A.W. v. Jersey City Public Schools*, 341 F.3d 234, 244 (3d Cir. 2003).

One reason is that States may always choose to decrease expenditures on other programs or to raise revenues. These alternatives ensure that the States

have a real choice to decline even large offers of federal aid. For this reason, the difficulties that accompany a decision to decline federal funding are merely part of the "ordinary *quid pro quo* that the Supreme Court has repeatedly approved." *Jim C.*, 235 F.3d at 1081. As a result, the courts have almost universally recognized that ordinary spending conditions like the ones at issue here simply do not implicate the coercion doctrine. *See, e.g.*, *California v. United States*, 104 F.3d 1086 (9th Cir. 1997) ("The *Dole* court concluded, however, that it would only find Congress' use of its spending power impermissibly coercive, if ever, in the most extraordinary circumstances.").

B. The ACA Is Not Coercive Even Under the Fourth Circuit's Standard.

In light of the numerous cases upholding the conditions that Congress has placed on Medicaid as well as those imposed on other large federal grants, the challengers apparently recognize that they cannot prevail under the standards applied by every circuit other than the Fourth Circuit. *See* Pet. 14 (claiming that the coercion doctrine "has been largely ignored and even expressly rejected by multiple courts of appeals"). As a result, they ask this Court to adopt the approach espoused in dictum by a plurality of the Fourth Circuit in *Va. Dept. of Education v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (*en banc*), which they claim is broader than the standard used in other circuits. Pet. 19 (commending the Fourth Circuit's approach in *Riley*). Although the Fourth Circuit has subsequently emphasized that *Riley*'s discussion of coercion is not even binding precedent in that circuit, *West Virginia v. HHS*, 289

F.3d 281, 291 (4th Cir. 2002), it bears emphasis that the ACA meets even the supposedly more demanding standard articulated in *Riley*.

In the *Riley* plurality opinion, Judge Luttig stated in dictum that a serious Tenth Amendment issue would be presented if Congress were to "withhold[] the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some insubstantial respect rather than submit to the policy dictates of Washington in a matter peculiarly within their powers as sovereign States." 106 F.3d at 570. Thus, to meet the standard articulated by Judge Luttig, the challengers would need to show that the conditions imposed by the ACA are *insubstantial* and that the federal government has withheld *all* of their Medicaid funding for failing to meet these insubstantial conditions. But, of course, neither of these statements is true. The obligation to expand coverage is not insubstantial, as challengers apparently demonstrate by arguing that the expansion is too onerous. Indeed, near-universal coverage for the poor is now an important part of Medicaid as Congress has designed it.

In addition, Congress did not condition all of a State's federal funding on compliance with the ACA's Medicaid expansion. In fact, as the Eleventh Circuit correctly noted, Congress did not even condition a State's entire *Medicaid funding* on compliance with the expansion. Rather—consistent with the funding structure it has always used—Congress provided that if a State fails to amend its plan to comply with the expanded-coverage requirements, HHS has discretion *either* to discontinue all of that State's

Medicaid funding *or* to discontinue a lesser portion. 42 U.S.C. § 1396c.

Only a few years after *Riley,* the Fourth Circuit itself confirmed that Medicaid's conditional-funding structure does not amount to coercion, even under the Fourth Circuit's supposedly broader standard. In *West Virginia v. HHS*, West Virginia challenged a 1993 amendment to the Medicaid Act that required States to "recover certain Medicaid costs from the estates of certain deceased beneficiaries," whereas these recovery programs had previously been optional. 289 F.3d at 284. As with the ACA, Congress imposed the requirement by mandating its inclusion in the Medicaid plans that the States submit to the U.S. Department of Health and Human Services. *See* 42 U.S.C. § 1396p(b). West Virginia argued that the new condition was coercive because it conditioned a State's entire Medicaid budget on its compliance with a relatively minor condition, which required West Virginia to recover "approximately two-tenths of one-percent of the more than $1 billion in Medicaid funds received by the state each year." *West Virginia*, 289 F.3d at 285. But the Fourth Circuit found that the new condition was not coercive because, contrary to West Virginia's assertion, the Medicaid Act did not require the Secretary of HHS to withhold *all* of the Medicaid funding of a State that violates the conditions of Medicaid participation. *Id.* at 291-92. Rather, the Medicaid Act gave the Secretary of HHS discretion to withhold either all *or* a smaller amount of the State's Medicaid funding. *See* 42 U.S.C. § 1396c (noting that if a State fails to administer its Medicaid program in accordance with its plan, "the Secretary shall notify such 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)"); 42 C.F.R. § 430.12(c)(1)(i) (requiring every state plan to provide that it will be amended whenever necessary to comply with changes in federal law). The Fourth Circuit found this point to be dispositive. *West Virginia,* 289 F.3d at 292.

As the Eleventh Circuit properly noted, the same reasoning disposes of this case. Pet. App. 62a. The ACA does not require the federal government to discontinue all Medicaid funding to a State that fails to carry out the ACA's mandate to expand Medicaid coverage. Rather, the ACA requires the States to amend their Medicaid plans to comply with new requirements of federal law—including the ACA. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 430.12(c)(1)(i). If a State fails to comply, the statute allows the Secretary of HHS the discretion either to discontinue Medicaid payments or to determine that "payments will be limited to categories under or parts of the State plan not affected" by the breach of the Medicaid conditions. 42 U.S.C. § 1396c(2). Thus, it would be well within HHS's discretion to discontinue merely a portion of a State's Medicaid funding.

In the view of the *amici*, no test such as the one proposed by Judge Luttig should be adopted. Rather, Congress should be free to condition participation in a federal program on compliance with the terms of the federal program. But it bears note that the ACA would pass muster under the most restrictive reading of the Spending Clause proposed by a federal judge.

C. The Eleventh Circuit Correctly Found that the ACA Is Not Coercive.

There are other reasons to conclude that the ACA is not coercive. The Eleventh Circuit discussed four of them, each of which was correct.

First, as the Eleventh Circuit noted, Congress made clear when it began Medicaid that it reserved the right to change the program. *See* Pet. App. 60a-61a (citing 42 U.S.C. § 1304). The challengers quibble with this analysis under the theory that this analysis "confuses foreseeability and coercion." Pet. Br. 41. But foreseeability is highly relevant to the analysis. The challengers have always known that Congress could change even the basic structure of Medicaid at any time. This possibility of changes in funding conditions was part of the bargain that the States voluntarily accepted when they initially chose to accept federal Medicaid funding.

Second, as also noted by the Eleventh Circuit, the federal government will pay for nearly all of the expansion. Pet. App. 61a. Unlike past Medicaid expansions—where the federal medical assistance percentage for some States was as low as 50 percent—the federal government will ultimately reimburse States for 90 percent of the benefits paid on behalf of individuals made eligible by the expanded coverage requirements. ACA § 2001(a)(3)(B); HCERA § 1201. In addition, the ACA will actually reduce the States' costs of caring for the uninsured—between $92 and $129 billion from 2014 to 2019 alone. *See* Matthew Buettgens *et al.*, *Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less*

With the ACA than Without It from 2014 to 2019 (Urban Institute July 2011).[5]

The challengers ask the Court to disregard these benefits, claiming that this Court should focus only on the amount of money the States stand to lose if they opt out of Medicaid. But the Eleventh Circuit squarely addressed why the ACA's 90-percent reimbursement rate is relevant to the coercion analysis: the challengers have argued that the ACA coerces them to spend more money in an endless cycle that will eventually break state budgets. But as the Eleventh Circuit explained, "If states bear little of the cost of expansion, the idea that states are being coerced into spending money in an ever-growing program seems to us to be 'more rhetoric than fact.'" Pet. App. 61a-62a.

Third, the challengers "have plenty of notice—nearly four years from the date the bill was signed into law—to decide whether they will continue to participate in Medicaid by adopting the expansions or not." *Id.* The challengers can hardly say that anything about the bill's timing has prevented them from making alternative arrangements if they wish to drop out of Medicaid.

Finally, the States have the alternative to decrease spending on other programs, raise revenue, or simply reduce the level of healthcare coverage for low-income people in the State if they wish to decline federal funding. Pet. App. 62a. Although this fact would seem to be indisputable and several other circuits have relied on it in rejecting coercion claims,

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[5] *Available at* http://www.urban.org/UploadedPDF/412361-consider-savings.pdf.

see Jersey City Public Schools, 341 F.3d at 243-44; *Pace v. Bogalusa City School Board,*, 403 F.3d 272, 278 (5th Cir. 2005), the challengers claim—somewhat astoundingly given that several of the challengers have no personal income tax and that many of the challengers have among the lowest tax burdens in the country, *see* Gov't Mem. re SJ at 46—that they actually have no power to raise alternative sources of Medicaid funding. Their justification for this claim boils down to a mere policy preference: the challengers do not wish to cut other programs or increase state tax rates. Pet. Br. 44. While there is always room for differences of opinion about whether programs should be cut, revenues should be raised, or healthcare coverage should be reduced in the State, there can be no dispute that resolving this issue is a political question and not a proper matter for judicial resolution. The challengers do not even attempt to show that they *cannot* cut other programs or raise taxes; they merely assert that they do not wish to do so. This is precisely the sort of "hard choice" that the courts have routinely found not to be coercive.

D. The States' Own Actions Indicate That They Have a Genuine Choice Whether to Participate in Medicaid.

In addition to the reasons articulated by the Eleventh Circuit, the challengers' coercion argument also rings hollow in light of the debates that have raged in several of the challengers' States about whether it might even be a *good policy* to decline Medicaid funds. Spurred in part by a Heritage Foundation report that erroneously concluded that the States would save a trillion dollars by dropping

out of Medicaid,[6] officials in a number of States began to actively support dropping out of Medicaid. For example, in Florida, State Senator Joe Negron—the "lead author of a proposal to overhaul the state Medicaid program"—told reporters only a year ago that "'[i]f the federal government elects not to allow us to manage the [Medicaid] program the way we believe is in Florida's best interests, then we'll operate our Medicaid program with our resources.'" *Florida Might Try to Withdraw from Medicaid*, Florida Times Union (Feb. 16, 2011).[7] Nor did Senator Negron believe that the large amount of federal funding at stake would stop Florida from making a free decision about whether to drop out: "Negron said the state would use its own portion of projected Medicaid spending to provide what benefits it could, giving priority to 'those on Medicaid that we believe are the most vulnerable and need the most assistance from us.'" *Id.*

Florida is not alone. As the Wall Street Journal reported in November 2010, "Elected and appointed officials in nearly a half-dozen states, including Washington, Texas and South Carolina, have publicly thrown out the idea" of "dropping out of the Medicaid insurance program for the poor." Janet Adamy and Neil King Jr., *Some States Weigh Unthinkable Option: Ending Medicaid*, Wall St. J.

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[6] *See* Dennis Smith and Edmund Haislmaier, *Medicaid Meltdown: Dropping Medicaid Could Save States $1 Trillion* (Heritage Foundation 2009), *available at* http://www.heritage.org/research/reports/2009/11/medicaid-meltdown-dropping-medicaid-could-save-states-1-trillion.

[7] *Available at* http://jacksonville.com/news/florida/2011-02-16/story/florida-might-try-withdraw-medicaid.

(Nov. 22, 2010).[8] Although experts characterized the proposal as "so extreme that even proponents don't expect any state will follow through," that does not change the fact that refusing Medicaid funding is a real option that a number of States have actively considered. *Id*.

Some States even conducted formal studies of the possibility. One such study, authored by the Texas Health and Human Services Commission, discussed exactly the sorts of policy tradeoffs that States would have to make in order to opt out of Medicaid: "Opting out of Medicaid would require state policymakers to carefully prioritize services and take a practical approach to establishing financial and categorical eligibility standards. Individual responsibility and a pay for performance reimbursement system should be at the foundation of any new program." Texas Health and Human Services Commission and Texas Department of Insurance, *Impact on Texas if Medicaid Is Eliminated* at 32 (Dec. 2010).[9] Although the report ultimately suggested that "[r]edefining the relationship between the state and federal governments in the administration of the Medicaid program may be a preferable course of action" to refusing Medicaid funding altogether, *id.*, it seriously proposed a number of options that the State could take if it chose to drop out of Medicaid.

Of course, *amici* believe strongly that it would be a terrible policy decision for Texas—or any other State—to choose to drop out of the Medicaid

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[8] *Available at* http://online.wsj.com/article/SB10001424052748704444304575628603406482936.html.

[9] *Available at* http://www.hhsc.state.tx.us/hb-497_122010.pdf.

program. This is likely the reason that many of the challengers have reversed course and now claim that it is impossible for them to refuse federal Medicaid funding. But of course the challengers' recognition that refusing Medicaid funding would be bad policy does not mean that doing so is impossible—just as the States' recognition in *Dole* that refusing federal funding would be a poor policy decision did not make the funding conditions on federal highway money unconstitutionally coercive.

III. ACCEPTING THE CHALLENGERS' ARGUMENTS WOULD UNSETTLE MEDICAID, UPEND MANY OTHER AREAS OF LAW, AND UNDERMINE CONGRESS'S ABILITY TO LEGISLATE.

As explained already, the ACA is by no means unique—a fact that strongly suggests that it does not present the sorts of extraordinary circumstances that would amount to coercion. For this reason, a ruling in favor of the challengers would have far-reaching effects beyond the ACA.

A. Reversal Would Call Prior Medicaid Expansions into Doubt.

Since its enactment in 1965, the Medicaid program has always invited States to accept significant federal funding in return for providing coverage for certain specified groups of people (although States are always free to cover additional groups). Since that time, Congress has enacted numerous expansions requiring the States to cover additional groups or to provide additional services to those groups already covered. For example:

> Congress embarked in 1984 on a series of Medicaid expansions that continued each year through the end of the decade. The expansions affected nearly the entire spectrum of Medicaid enrollees from infants, children, and pregnant women to low-income Medicare beneficiaries, and other aged and disabled enrollees. Initially, States were offered options to expand coverage of these groups, but ultimately most of the options were converted by subsequent legislation into mandates, most notably in the Medicare Catastrophic Coverage Act of 1988 (MCCA).

Medicaid Spending at 108.

If this Court invalidated the ACA as impermissibly coercive, many—if not all—of these prior expansions would be called into doubt. That is because past expansions have typically been achieved in the same way as the ACA's expansion—by amending 42 U.S.C. § 1396a(a) to require a state plan to cover additional patients or services. To give only a few examples, in 1984 Congress expanded Medicaid to cover children whose families met the income requirements for Aid to Families with Dependent Children but were not eligible for AFDC—coverage that had previously been optional. *See* American Academy of Pediatrics ("AAP") 11th Cir. Br. at 21 (Apr. 12, 2011); Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 § 2361. Similarly, in 1988 Congress mandated expansion of coverage for pregnant women and young children—coverage which had previously been optional. *See* AAP 11th Cir. Br. at 21. These past expansions thus offered the States the same choice the ACA offers

here—provide the additional coverage or risk losing some or all Medicaid funding.

The challengers seek to avoid the fact that their argument would call past Medicaid expansions into question on the ground that less Medicaid funding was at issue. But the conditions imposed by past expansions remain conditions today and thus potentially condition all of a State's *current* Medicaid funding on compliance with their terms. If a State decided today not to comply with the conditions imposed by past expansions, it would risk losing all or part of its Medicaid grant.

Because past Medicaid expansions are indistinguishable from the ACA, a decision in favor of the challengers would threaten the Medicaid program as we know it, potentially leaving many of the citizens who depend on Medicaid without coverage. This point has not been lost on even the most vocal critics of the ACA, who have warned that striking the ACA as coercive could be disastrous. As Senator Charles Grassley (R-Ia.) explained recently, "A Supreme Court ruling in favor of the States in this case could not only jeopardize the mandated Medicaid expansion in the Affordable Care Act but could challenge the fundamental structure of Medicaid and have broader implications outside health care." 157 Cong. Rec. S8670, S8671 (daily ed. Dec. 15, 2011).

B. Reversal Would Call Many Other Programs Into Question Because Congress Routinely Places Conditions on the Receipt of Federal Funding.

A ruling in favor of the challengers would have effects far beyond Medicaid. It would call into question every federal law that imposes conditions on a significant amount of federal funding. These laws are ubiquitous across the political spectrum and range from cooperative federal-state programs to funding conditions imposed on all recipients of federal funding. They include programs like foster care, which provides billions of dollars in matching assistance to States, eligibility for which is subject to the State submitting a plan meeting numerous conditions indistinguishable from those imposed on the receipt of Medicaid funding. *See* 42 U.S.C. § 671. They also include numerous funding conditions that prevent discrimination by recipients of other sources of federal funding—including, for example, Title VI of the Civil Rights Act of 1964 (which prohibits racial discrimination "under any program or activity receiving Federal financial assistance," 42 U.S.C. § 2000d; *see also* 42 U.S.C. § 2000d-1) and Title IX of the Education Amendments of 1972 (which prohibits gender discrimination in any "education program or activity receiving Federal financial assistance." 20 U.S.C.A. § 1681(a); *see also* 20 U.S.C. § 1682).

A ruling in favor of the challengers also would not be limited to programs at the progressive end of the political spectrum; it would also threaten, for example, the Solomon Amendment, which requires educational institutions to provide military recruiters access equal to that provided to other

recruiters or lose numerous categories of federal funding. *See* 10 U.S.C. § 983. This Court upheld the amendment only a few years ago, noting that "Congress's power to regulate military recruiting under the Solomon Amendment is arguably greater because universities are free to decline the federal funds." *Rumsfeld v. Forum for Academic & Inst. Rights, Inc.*, 547 U.S. 47, 59 (2006). And a ruling in favor of the challengers would undermine antiabortion legislation such as the No Taxpayer Funding for Abortion Act, H.R. 3, 112th Cong. (as passed by the House May 4, 2011), which would cut of federal funding for health-benefit plans—including state Medicaid plans—that cover abortion. *See* §§ *id.* 302, 305.

C. A Ruling For the Challengers Would Make It Difficult for Congress to Legislate.

The programs mentioned above are only a small subset of the numerous federal programs that condition substantial amounts of federal funding on the States' agreement to fulfill certain conditions—and for good reason. Without the ability to condition the receipt of funding on conditions, Congress would have very little control over how States use the funding it offers. Even the challengers appear to recognize that it would be absurd to construe the Spending Clause to require Congress to distribute money without imposing any conditions on the use of the funds.

Moreover, a ruling in favor of the challengers would greatly inhibit Congress's ability to create cooperative federal-state programs. At a minimum, such a ruling would prevent Congress from creating

large cooperative programs, since any condition on participation in the program could be deemed coercive simply because of the amount of money at issue.

But such a ruling would likely dissuade Congress from designing smaller programs because it would be impossible to predict where the courts would draw the line between a large coercive program and a small non-coercive one. In addition, smaller programs would likely be affected because it is difficult to predict whether a small federal-state partnership might grow. Medicaid provides a good example: it began small but blossomed. Complicating matters further, Congress often does not have complete control over how large a program grows: Medicaid has grown in large part because the States have chosen to cover optional populations and services.

Ironically, then, a ruling in favor of the challengers would likely have a negative effect on our federalism. Because such a ruling would leave Congress with little control over how the States use federal grant money, Congress would be much less likely to make grants to the States at all, avoiding federal-state cooperative programs like Medicaid in favor of direct federal programs like Medicare. That result would lessen, not increase, state autonomy.

Congress could have chosen to federalize the Medicaid program, eliminating the States' role altogether. Perhaps some of the challengers would have preferred that option, but that would have left States with much less say over the design and implementation of the Medicaid program. Instead, Congress has chosen to work cooperatively with

States that volunteer to participate in the program, allowing States a great deal of autonomy to decide how much to reimburse providers and which optional populations to cover, among other things. But if this Court were to force Congress's hand, Congress could eliminate state participation in Medicaid altogether—leaving both the States and Congress worse off.

CONCLUSION

The Eleventh Circuit's judgment upholding the ACA's Medicaid expansion provision should be affirmed.

Respectfully submitted,

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