IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

Case No.: 3:10-cv-91-RV/EMT

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THE PEOPLE OF MICHIGAN;

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STATE OF NEVADA, by and through JIM GIBBONS, GOVERNOR OF THE STATE OF NEVADA;

STATE OF GEORGIA, by and through SONNY PERDUE, GOVERNOR OF THE STATE OF GEORGIA;

STATE OF ALASKA, by and through DANIEL S. SULLIVAN, ATTORNEY GENERAL OF THE STATE OF ALASKA;

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, a California nonprofit mutual benefit corporation;

MARY BROWN, an individual; and

KAJ AHLBURG, an individual;

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHLEEN SEBELIUS, in her official capacity as the Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF THE TREASURY; TIMOTHY F. GEITHNER, in his official capacity as the Secretary of the United States Department of the Treasury; UNITED STATES DEPARTMENT OF LABOR; and HILDA L. SOLIS, in her official capacity as Secretary of the United States Department of Labor,

Defendants.

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

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Plaintiffs hereby submit this memorandum in opposition to Defendants' Motion for Summary Judgment. As shown below – and as supported by Plaintiffs' Response to Defendants' Statement of Material Facts ("PRSOMF") and Supplemental Appendix ("Pl.Supp.App."), as well as the materials previously submitted in support of Plaintiffs' Motion for Summary Judgment – Defendants are not entitled to judgment in their favor on any claims in the Amended Complaint. Accordingly, their motion must be denied.

Introduction

As Plaintiffs have shown in their Motion for Summary Judgment [Doc. 80-1], the Patient Protection and Affordable Care Act[1] ("ACA" or "the Act") exceeds Congress's powers under Article I and violates the Ninth and Tenth Amendments. To sustain the Act, Defendants ask the Court to rewrite the Constitution and fundamentally alter the relationships between the federal government and the States and between the federal government and the American people. The Court should refuse this invitation.

A. The Individual Mandate Exceeds the Commerce Power

The Individual Mandate is unprecedented. It compels citizens to engage in commerce even though they have not themselves chosen to enter the marketplace. Never before has Congress purported to use its power over interstate commerce to *compel* activity, rather than to regulate *existing* economic activity. Nor has Congress ever suggested that such compulsion was "necessary" or "proper" for the regulation of interstate commerce. Moreover, prior to the ACA's enactment, no federal court ever had

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

endorsed the expansive view of the Commerce Clause and Necessary and Proper Clause on which Defendants' efforts to justify the mandate depend. Mem. Op. [Doc. 79] at 61.

Limiting the commerce power to the regulation of existing commercial activity, whether the activity is directly in or has a substantial effect on interstate commerce, provides a necessary and judicially manageable restraint on congressional authority – a restraint grounded in the text and history of the Constitution, as well as binding precedent. Although Defendants demand that the Court abandon this time-tested limitation on Congress's authority to regulate "Commerce ... among the several States," they can offer no substitute limiting principle that would prevent the Commerce and Necessary and Proper Clauses from becoming the very sort of general police power the Framers specifically denied to the federal government.

Moreover, such a ruling impermissibly would render numerous other powers of Congress redundant and limitations on Congress unavailing. This Court should not endorse a boundless expansion of federal power so at odds with the basic language and premises of the Constitution, its historical protection of the rights of the States and the People *vis-à-vis* the federal government, and the axiomatic rules of constitutional construction dating back to *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

B. The ACA's Medicaid Regime Impermissibly Coerces and Commandeers the States

The ACA further violates the Constitution by coercing the States' participation in its new Medicaid regime and by commandeering their resources to achieve the federal government's ends. The federal-State Medicaid partnership does not confer plenary power on the federal government to make *any* Medicaid revisions that it wishes,

irrespective of coercion or harm to the States. Where Medicaid was created as a federal-State partnership to provide funding to reimburse the healthcare costs of the poor and needy, the ACA scuttles that partnership and imposes a vastly transformed Medicaid on the States. Now, Medicaid funding is to be made available to everyone with an income up to 38 percent *above* the federal poverty level; the States (but *not* the federal government) are to assume responsibility for the *provision* of healthcare services (rather than merely reimbursing the costs of those services); and the States' flexibility to alter eligibility criteria and to control costs through the withdrawal of optional benefits – comprising more than 60 percent of Medicaid spending – has been removed. The ACA's Medicaid changes are forecast – by federal agencies tasked with scoring the ACA's projected impact, by States, and by another respected healthcare organization – to cost the States *at least* $20 billion by 2019, and more likely *double* that figure, not counting their added administrative overhead or the cost to them from becoming responsible for providing healthcare services. PRSOMF ¶¶ 40, 47. Indeed, the latter cost alone could bankrupt States, which probably explains why Congress refused to share that new burden. These greatly increased costs are imposed at a time when, by the federal government's own reckoning, the States must *decrease* their Medicaid outlays to avoid insolvency.

Congress's top-down transformation of Medicaid was done to advance the ACA's overarching goal of achieving near-universal healthcare insurance coverage. The Individual Mandate requires that virtually every American must obtain qualified coverage, and the Act provides four primary "doors" through which a person may pass to get that coverage: Medicaid, Medicare, statewide insurance exchanges, and employer

plans. Congress's overhaul of Medicaid widens that "door" considerably, in order to accommodate about 18 million (30 percent) more enrollees. PRSOMF ¶ 43.

Defendants ask the Court to believe that Medicaid remains purely voluntary, and that any State may simply withdraw to avoid the new costs and burdens. However, there is no mechanism under law for such a withdrawal – much less for an orderly transition that would not jeopardize the health and lives of the millions of poor and needy who depend on the States' Medicaid programs. Defendants' contention is especially disingenuous, because Congress very well knew in passing the ACA that withdrawal would not be a viable alternative for the States. The ACA's architecture inherently depends on the States remaining in Medicaid. A withdrawal would tear a gaping hole in the ACA's scheme, locking shut the "door" by which the Act provides for 70-80 million lower-income Americans to comply with the Individual Mandate; no federal provision is made to fund their healthcare needs *except through Medicaid*. States' withdrawal not only would frustrate the ACA's universal coverage objective, but would end up leaving the poorest and neediest out in the cold even while federal subsidies would be lavished on millions of other persons at far higher income levels.

Defendants' remaining contentions are specious. First, they note that the federal government will be spending more under the new Medicaid regime than will the States. But the level of the federal government's contribution fails to address the substantial new costs and burdens placed on the States. Moreover, likening federal and State fiscs is akin to comparing apples and oranges, because the States – unlike the federal government –

cannot tax at rates equal to the federal government, cannot print money to cover their debts, and cannot pile up deficits the size of the federal government's.

Second, Defendants offer the preposterous claim that the States will achieve net *savings* under the transformed Medicaid program. As a threshold matter, this claim is legally irrelevant to the coercion analysis. Defendants do not dispute the costs and burdens forced onto the States, but merely point to the *potential* for States to receive collateral benefits. In fact, Defendants have no credible support for their claim of offsetting savings. They place primary reliance on a report by the President's own Council of Economic Advisors ("CEA"), made months before the ACA's passage. But the CEA report is rife with error and mostly identifies potential "savings" that would not accrue to the States' fiscs at all; rather, the identified beneficiaries are *local* governments – and any savings to *them* are questionable and, if realized, might actually *increase* States' costs. PRSOMF ¶¶ 48-57. Hence, it is no wonder that the federal agencies and outside organizations that assessed likely projected costs of the ACA *did not even cite the CEA report*. Instead, they project significant net costs to the States, as do the sworn declarations from representatives of Plaintiff States' Medicaid agencies.

There is no room for reasonable disagreement: the transformed Medicaid regime far surpasses the point at which persuasion becomes coercion, in violation of the Constitution. In addition, it violates every restriction on Congress's spending power.

Finally, neither the ACA's Medicaid changes nor the Individual Mandate is severable from the other provisions of the ACA. The unconstitutionality of either requires that the Act be struck down in its entirety.

Argument

I. THE INDIVIDUAL MANDATE IS UNCONSTITUTIONAL

A. The Commerce Power Has Limits That Congress Must Respect

Congress's power under the Commerce Clause, even as augmented by the Necessary and Proper Clause, is not unlimited. It is firmly established that the Constitution created a federal government of limited, "'enumerated powers' ... which means that '[e]very law enacted by Congress must be based on one or more of' those powers." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (citations omitted). As a result, however broad Congress's enumerated powers may be, they cannot be interpreted in a manner that would encompass a general police power. *Id.* at 1964 (confirming that its decision does not "confer[] on Congress a general 'police power, which the Founders denied the National Government and reposed in the States.'") (quoting *United States v. Morrison*, 529 U.S. 598, 618 (2000)).

Several equally fundamental rules derive from that most basic premise. First, the Commerce Clause itself grants a limited power constrained by the very language of that provision. *United States v. Lopez*, 514 U.S. 549, 552–553 (1995) ("[t]he Constitution creates a Federal Government of enumerated powers," and there are limits that "are inherent in the very language of the Commerce Clause."); *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 194-95 (1824) (the very existence of an "enumeration presupposes something not enumerated") (quoted in *Lopez,* 514 U.S. at 551).

Second, the Necessary and Proper Clause, providing adjunct or incidental authority required for "carrying into Execution" Congress's regulation of interstate

commerce, likewise must be limited so that it does not vitiate the intrinsic limits on the underlying power.

Third, "[t]he commerce power – that is the combination of the Commerce Clause per se and the Necessary and Proper Clause," *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1249 (11th Cir. 2008), cannot be interpreted in a manner that renders meaningless either the Constitution's grant of other limited powers to Congress or the affirmative restrictions it imposes on those powers in general. "It cannot be presumed that any clause in the constitution is intended to be without effect; and therefore such a construction is inadmissible, unless the words require it." *Marbury*, 5 U.S. at 174.

In light of these fundamental principles, Defendants' attempts to justify the Individual Mandate all fail.

B. The Commerce Power Does Not Support the Individual Mandate

Defendants argue that the Individual Mandate falls within the commerce power because all individuals eventually will consume healthcare and some will be unable to pay for that care, effectively "shifting" these costs to third parties. Congress, Defendants claim, may preemptively require insurance to avoid such "cost-shifting." DMSJ [Doc. 82-1] at 25-27. However, this convoluted reasoning conflates actual commerce with potential future commerce, and with failures or refusals to engage in present commerce, ultimately collapsing into the proposition that the absence of engagement in one type of commerce (purchasing healthcare insurance) can be regulated by Congress because it may affect another type of commerce (the consumption of healthcare services) and the economy in general. Defendants' position is profoundly flawed.

1. The Individual Mandate Does Not Regulate the Healthcare Services Market

First, the Individual Mandate does not regulate the only actual commerce identified in Defendants' daisy-chain. The purchase of healthcare services is, of course, a commercial transaction, though it is typically a local and intrastate transaction rather than an interstate one.[2] But the mandate does not regulate the purchase or consumption of healthcare services. It does not constrain the type of care consumed or *require* consumers to pay for such care in any particular manner. Healthcare services still may be purchased on a pay-as-you-go basis, and often will be so purchased, particularly where any desired care exceeds the coverage of ACA-approved insurance policies. Thus, requiring individuals to purchase healthcare *insurance* does not regulate the consumption of healthcare *services*.[3]

2. The Commerce Power Only Reaches Activity

Second, the Individual Mandate does not regulate any "activities" that constitute interstate commerce or that "substantially affect interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 16–17 (2005). Compelling individuals to engage in a particular type of commerce, in order to create economic activity, is not the *regulation* of interstate

[2] Any regulation of such intrastate transactions thus already is one step removed from the regulation of interstate commerce and could be justified only because it might have an effect on interstate commerce and be necessary and proper to carry into execution the regulation of such interstate commerce.

[3] In this connection, Defendants also incorrectly assert that the Individual Mandate may constitutionally be applied to those who *now* have healthcare insurance – presumably on the assumption that having entered the market for such insurance they may never leave it. There is no authority for such a proposition.

commerce. That power presupposes the existence of the commerce being regulated.[4] Here, Congress seeks to regulate inactivity, or the *absence* of interstate commerce, by forcing commercial transactions on those who elect not to purchase insurance and thus *not* to engage in current interstate commerce. Notwithstanding Defendants' verbal gymnastics, inactivity or the absence of commerce cannot be conflated with activity and commerce without rendering the word "commerce" itself meaningless.

Moreover, as the very enumeration of a power to regulate interstate commerce "presupposes something not enumerated," *Lopez,* 514 U.S. at 551 (quoting *Gibbons v. Ogden*, 22 U.S. at 194-195), there must be a category of "*non*-interstate commerce" – *i.e.*, economic activity which truly is local and beyond Congress's reach. *Id.* at 557 (citing *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937)). One obvious and historically grounded aspect of the category of human existence not subject to the commerce power is simple passivity, or the failure to engage in commercial transactions.

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[4] This is a limit inherent in the text and structure of the Constitution itself. To the Framing generation, "commerce" was essentially "trade." Samuel Johnson, *A Dictionary of the English Language* (J.F. Rivington, et al., eds., 6th ed. 1785) ("Intercourse; exchange of one thing for another; interchange of any thing; trade; traffick."). *Accord* Noah Webster, *An American Dictionary of the English Language* (1828) ("an interchange or mutual change of goods, wares, productions, or property of any kind, between nations or individuals, either by barter, or by purchase and sale; trade; traffick."). Evidence from the drafting of the Constitution, the Federalist Papers, ratification debates and conventions, and early judicial interpretations confirms this understanding. *See* Randy E. Barnett, *The Original Meaning of the Commerce Clause*, 68 U. Chi. L. Rev. 101 (2001). Even scholars who have taken a broader view of the commerce power find a touchstone in activity. *See, e.g.,* Grant S. Nelson and Robert J. Pushaw, Jr., *Rethinking the Commerce Clause: Applying First Principles to Uphold Federal Commercial Regulations but Preserve State Control over Social Issues*, 85 Iowa L. Rev. 1 (1999) ("the voluntary sale or exchange of property or services and all accompanying market-based activities, enterprises, relationships, and interests"). *See Gibbons v. Ogden*, 22 U.S. at 189–90 ("intercourse").

That limitation on the Commerce Clause is necessarily recognized by the numerous cases describing the commerce power as applicable to "activities." As the Eleventh Circuit has made clear, the commerce power permits Congress to regulate "three categories of *activities*." *Garcia*, 540 F.3d at 1249 (emphasis added). These categories include: (1) "use of the 'channels' of interstate commerce;" (2) using the actual "instrumentalities" of interstate commerce; and (3) "purely intrastate activities when they 'substantially affect' or have a 'substantial relation to' interstate commerce." *Id.* at 1249-1250, citing *Raich*, 545 U.S. at 25, and *Lopez*, 514 U.S. at 558, among other authorities.

Nor does the Individual Mandate regulate a commercial or economic "activity" that substantially affects interstate commerce. While Congress also can regulate certain purely intrastate and local commercial activities under the Necessary and Proper Clause, it still must direct such a regulation to an *existing* commercial activity. *Garcia*, 540 F.3d at 1250 ("intrastate activities"). Defendants have not identified a single case (with the exception of the wrongly decided *Thomas More Law Center v. Obama*, 2010 WL 3952805 (E.D. Mich. Oct. 7, 2010)) even suggesting that the commerce power reaches beyond the regulation of actual economic *activity*.

3. Inactivity Cannot be Redefined as "Economic Activity"

Defendants engage in Orwellian efforts to redefine the inactivity of not having healthcare insurance as an affirmative economic activity of "deciding" not to buy insurance, or deciding *now* how to pay (or not to pay) for potential *future* economic activity in the form of obtaining medical services. These efforts are insupportable by language, law, reason, and precedent. To be "active" in a market, a person must be

selling, buying, producing, transporting, using, or possessing a good or service available in that market. The same is true of both the market for healthcare services and the market for healthcare insurance. There is nothing "unique" about those markets.[5]

If the "decision" not to engage in commerce is an economic activity that may be regulated either as interstate commerce itself, or as having a substantial effect on interstate commerce, then the very notion of "commerce" is empty of meaning and encompasses everything. Under Defendants' theory, all decisions in life can be recast as decisions to forego some alternative economic activities, and therefore fall under Congress's reach. The decision to sleep becomes a decision not to work, and hence an economic activity. The decision to rest on the weekend becomes a decision not to engage in commercial behavior. The decision to go to high school or college becomes a decision to postpone entry into the labor market. As the *Lopez* Court correctly explained, such tortured reasoning "lacks any real limits because, depending on the level of generality, any activity can be looked upon as commercial." *Lopez*, 541 U.S. at 565.

It is no answer to state the obvious point – and one of which the Supreme Court surely has been aware all along in limiting the commerce power to activity – that the absence of consumers, *i.e.*, their inactivity, can have secondary effects on a market. The lack of demand for, *e.g.*, orange juice can impact citrus growers, processors, marketers,

[5] As noted below, one of Defendants' own experts indicates that these two "markets" are, in fact, quite separate and distinct. *See infra* at 22-23. Defendants have not explained how the alleged characteristics of the market for medical services render the market for healthcare insurance different from any other insurance market involving the management of widely-shared significant risks, such as the markets for life insurance or disability insurance.

and sellers, on the supply side; and it can affect prices paid by consumers, on the demand side (depending on how the aggregate supply is adjusted). But these are effects on persons or businesses *who are voluntarily active in the market.* The same can be said of virtually any conceivable market. Inactivity of itself is neither "economic" nor "financial," despite Defendants' claims to the contrary. DMSJ at 27.

Similarly, as with healthcare, the timing of individual entries (and exits) in markets generally, including markets for necessities, is unpredictable and can involve extensions of credit and substantial costs which many consumers, at length, may be unable to pay. Their defaults result in the same "cost-shifting" that Defendants wrongly contend applies solely to healthcare. But cost-shifting takes place among *active market participants*, as losses caused by defaulting consumers are either absorbed by suppliers or passed along to other participants – *all of whom are voluntarily active in the market*.[6]

Moreover, Defendants' absurd claim that anyone without healthcare insurance is "engaged in economic activity to an even greater extent than the plaintiffs in *Wickard* or *Raich*," DMSJ at 29, not only defies language and logic, but also ignores the genuine *activities* regulated in those and other cases. As the Court already has noted with respect to *Wickard v. Filburn*, 317 U.S. 111 (1942) and *Heart of Atlanta Motel v. United States*, 379 U.S. 241 (1964), Congress merely was regulating the economic and commercial activities in which the complainant parties had *chosen* to engage. Mem. Op. at 62-63. In

[6] In this regard, it is worth emphasizing that cost-shifting is ubiquitous in all segments of the modern economy, because of the widespread availability of credit and the increasing rarity of cash payment for goods or services upon delivery. The consequences for the economy in such cases may differ in degree, but not in kind, from those attending the healthcare market.

Wickard and *Raich*, Congress regulated commodities indisputably within its reach, and the parties could have avoided federal regulation through the simple expedient of choosing not to grow, consume, or use the relevant substances.

The same is true of every appeals court case Defendants cite. *See United States v. Ambert*, 561 F.3d 1202, 1211 (11th Cir. 2009) (regulating sex offenders when they "travel[] in interstate or foreign commerce"); *United States v. Gould*, 568 F.3d 459, 470 (4th Cir. 2009) (same); *United States v. Olin Corp*., 107 F.3d 1506, 1510 (11th Cir. 1997) (regulating "the disposal of hazardous waste"); *United States v. Maxwell*, 446 F.3d 1210, 1216–17 (11th Cir. 2006) (regulating "the receipt, distribution, sale, production, possession, solicitation and advertisement of child pornography"); *Alabama-Tombigbee Rivers Coal. v. Kempthorne*, 477 F.3d 1250, 1272, 1277 (11th Cir. 2007) (regulating the "tak[ing]" of endangered fish); *United States v. Belfast*, 611 F.3d 783, 793, 814 (11th Cir. 2010) (punishing violence and use of a firearm); *Garcia*, 540 F.3d at 1252 (regulating "the commercial leasing of cars"); *United States v. Williams*, 121 F.3d 615, 618–19 (11th Cir. 1997) (regulating the obligation to "pay money" in the form of a child support award which "crossed state lines."). In each case, the courts upheld the regulation of an *activity*.

4. Defendants Can Identify No Meaningful Limiting Principle

Defendants' argument leads inexorably to an infinite commerce power and leaves this and other courts with no coherent or judicially manageable doctrine to limit Congress to its enumerated powers, or to preserve some non-redundant purpose for many other parts of the Constitution. If the Commerce Clause is as broad as Defendants claim, it is difficult to imagine any requirement or regulation that would be beyond it. Indeed, under

Defendants' theory, it is inexplicable why the Constitution's Framers found it necessary to enumerate so many other powers to be vested in Congress – for example, the powers to establish uniform laws on bankruptcies, to coin and regulate the value of money, to punish counterfeiting, to establish post offices and post roads, to provide for patents and copyrights, and to define and punish piracy. U.S. Const. Art. I, § 8, cls. 2, 3, 4, 5, 6, 7, 9.

The exercise of these powers (and many more) certainly falls well within the expansive commerce power Defendants posit, and therefore would be redundant or meaningless in light of so broad a commerce power. Such an interpretation of the Constitution is impermissible. *See Marbury*, 5 U.S. at 174 ("[i]t cannot be presumed that any clause in the constitution is intended to be without effect; and therefore such a construction is inadmissible, unless the words require it.").[7] Defendants' entire theory of the case – that individuals who are absent from a market can be regulated by Congress even though they have not voluntarily engaged in any commercial activity – admits of no limiting principle, and Defendants have not identified any.

5. Limiting the Commerce Power to Commercial Activities Is a Necessary Constraint on Congress

Far from "empty formalism," DMSJ at 16, limiting the commerce power to the regulation of activities is necessary to the judicial enforcement of any other limits on

[7] Defendants suggest that the Bill of Rights would remain as some limit on congressional power. DMSJ at 23. This, however, is not the Constitution's design. Congress's authority is limited both by the limited and enumerated nature of its powers, *see, e.g., Lopez*, 514 U.S. at 553 (noting that "limitations on the commerce power are inherent in the very language of the Commerce Clause."), and by the Bill of Rights. Elimination of the constraints inherent in Article I cannot be justified by reference to the continuing existence of those contained in the Bill of Rights. Moreover, Defendants' position would also render any analysis of "rationality" under the Due Process Clause superfluous.

congressional power.[8] It is this most fundamental constraint which keeps Congress's broad authority to regulate interstate commerce from becoming an impermissible general federal police power, and which provides a clear and judicially enforceable limiting doctrine. *Cf. Comstock*, 130 S. Ct. at 1964 ("'Nor need we fear that our holding today confers on Congress a general 'police power, which the Founders denied the National Government and reposed in the States.'") (quoting *United States v. Morrison*, 529 U.S. 598, 618 (2000)).

Like the commercial/non-commercial limiting doctrine set out in *Lopez*, the activity/inactivity line has a long history of practical adherence and recognition. The novelty of Congress's current attempt to escape this prior limit – and hence the dearth of case authority enforcing that limit – confirms its existence and vitality.

6. Only a Forbidden Police Power Could Support the Mandate

Only a forbidden "police power that would authorize enactment of every type of legislation," *Lopez*, 514 U.S. at 566, could support the Individual Mandate.[9] Defendants have no answer to this point. Indeed, their references to other instances in which Congress has imposed "mandates" are as inapposite as the authorities they cite, because

[8] Moreover, as the Supreme Court explained in *New York v. United States*, 505 U.S. 144, 187 (1992), "[m]uch of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measures deviating from that form. The result may appear 'formalistic' in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions."

[9] The ability to regulate individuals based only on their presence in a jurisdiction is, of course, the defining characteristic of a "police power." *Cf. Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (upholding State's right to require an individual's smallpox vaccination simply because he was present in the State).

in those cases Congress relied on *other* enumerated powers, not the Commerce Clause. DMSJ at 32. In each such case, the mandate was grounded in a grant of authority that necessarily included the power to command the service of individuals as a matter of law, logic, and longstanding practice based on the most fundamental attributes of citizenship. *See, e.g.*, *Selective Draft Law Cases*, 245 U.S. 366, 378–79 (1918) (authority to compel service recognized as inherent in the very notion of citizenship and the power to raise and support armies); *In re: Heritage Propane*, 2007 U.S. Dist LEXIS 88933, *4, *7 n.3 (E.D. Tenn. Feb. 6, 2007) ("The right to a jury trial is a fundamental part of the American judicial system," and as a result, "[t]he jury is as much an institution of self government as is the election of public officials. Jury service on the part of citizens of the United States thus has become one of the most important and basic rights and obligations of citizenship.").[10]

The Commerce Clause, by contrast, suggests no such power to dragoon the citizenry into the service of Congress's national policy goals.[11] Certainly, enactment of

[10] *In Re Quarles*, 158 U.S. 532 (1895), cited by Defendants, is inapposite. The case stands only for the proposition that the federal government may provide, through a prohibition on criminal conspiracies, for the protection of witnesses and informants. It does not establish any legally enforceable requirement that a citizen must do anything, much less that the commerce power would allow Congress to impose such a requirement. *Id*. at 535 (analogizing citizen's duty to come forward with evidence of a crime to duty to act as part of the *posse comitatus*). In any case, service in the "posse comitatus" also was a recognized incident of citizenship at the time the Constitution was ratified. *Mejia v. City of New York*, 119 F. Supp. 3d 232, 262 & n.33 (E.D.N.Y 2000). The existence of such authority says nothing whatsoever about the proper scope of the commerce power.

[11] Indeed, Defendants are oblivious to the fact that their argument would fundamentally redefine the nature of federal citizenship, altering the relationship between the federal government and the People and violating a number of constitutional provisions. For an argument that this would violate the Tenth Amendment, *see* Randy E. Barnett,

the Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA" or "Superfund") provides no such precedent. Contrary to Defendants' claims, DMSJ at 30-31, CERCLA only imposes a "mandate" based on various activities, including ownership and possession, related to the disposition of hazardous materials. 42 U.S.C. § 9607(a). The fact that a particular owner may not have caused the relevant environmental damage is irrelevant to questions of liability, but ownership or possession of the source of the damage is relevant – which is why an entire industry providing "environmental audits" has blossomed since Superfund's passage in 1980. Land titles now carry with them obligations that, once title is taken, cannot necessarily be discharged by sale or other disposition of the property. These obligations, however, *can be avoided* by not becoming involved in the disposition of hazardous wastes or by not taking title to property where such wastes may be present.[12]

Finally, the constitutional implications of Defendants' argument are both profound and staggering. Defendants suggest that every individual is a "market participant" because every individual either has used or will use healthcare services at

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Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional, NYU J.L. & Liberty (forthcoming), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1680392.

[12] Eminent domain, also cited by Defendants, likewise is inapposite. Although euphemistically described as a "forced sale" (a term not embraced by the Court in *Luxton v. North River Bridge Co.*, 153 U.S. 525 (1894)), the exercise of the power of eminent domain in fact involves the *taking* of private property for public purposes. *Id.* at 529. It is the land, and not the landowner, that is subject to condemnation and the object of governmental power. *See, e.g., Kelo v. City of New London*, 545 U.S. 469, 483–84 (2005). Similarly, each of the various insurance "mandates" cited by Defendants also is contingent on, and regulates, specific economic activities. DMSJ 30 n.9.

some point in time, making everyone subject to regulation under the Commerce Clause. The foundation of this position, of course, is that no one can avoid this particular market and, once in the market, no one may withdraw. Moreover, while permanently a part of this eternal market, everyone would be subject to regulation, and that regulation would not be limited to an individual insurance mandate. Like the businesses regulated by the Fair Labor Standards Act, individuals could be required to provide benefits and services as Congress deemed appropriate. No one, from birth to death, could avoid being regulated. Like the Individual Mandate itself, such absolute federal power over any aspect of life is unprecedented and insupportable based on the text, history and consistent interpretation of the Constitution.

C. The Mandate Cannot Be Saved by the Necessary and Proper Clause

1. The Individual Mandate Fails under the *Comstock* Factors

As Plaintiffs have demonstrated in Pl.Opp.MTD [Doc. 68] at 33-36 and PMSJ [Doc. 80-1] at 17-23, the Individual Mandate plainly fails every consideration identified by the Supreme Court in *Comstock*, its latest opinion dealing with the Necessary and Proper Clause (albeit not in the context of the commerce power). The Individual Mandate is by no means a "modest" or "narrow" provision; it is not supported by any long "history of involvement" of Congress in compelling the purchase of insurance; it is not the "means for implementing a constitutional grant of legislative authority," as shown below; and it does not "properly account[] for State interests," as shown above. *See Comstock*, 130 S. Ct. at 1962. Instead, the mandate represents an unprecedented intrusion of federal governmental power into Americans' lives, and in effect creates a

general federal police power that is reserved to the States under the Constitution. As a consequence, the Necessary and Proper Clause cannot rescue the mandate.

2. The Mandate Is Not "Essential" to a Larger and Legitimate Regulatory Scheme

The Individual Mandate also cannot be sustained as an "essential" part of some larger and legitimate regulatory scheme. Defendants' reliance on *Raich* in this respect is particularly misplaced. The *Raich* Court upheld Congress's regulation of purely intrastate cultivation, possession, and use of marijuana as being "essential" to its larger scheme to regulate dangerous drugs, entirely eliminating certain of these from the interstate market through the Controlled Substances Act ("CSA"). It did so because these intrastate "*activities*" were the same as those "quintessentially economic" activities regulated on the interstate level by the CSA, reasoning that "prohibiting the intrastate possession or manufacture of an article of commerce is a rational (and commonly utilized) means of regulating commerce in that product." *Raich*, 545 U.S. at 24-26 (emphasis added). Failing to regulate "such a significant segment of the total market would undermine the orderly enforcement of the entire regulatory scheme." *Id.* at 28.

The Individual Mandate does not regulate any activity, economic or otherwise, which could undermine enforcement of another regulatory scheme. Nor does the mandate serve to implement an otherwise legitimate regulation of interstate commerce, as did the recordkeeping requirements upheld as necessary and proper in *United States v. Darby*, 312 U.S. 100, 124–125 (1941). It is, in fact, a measure directly designed to achieve Congress's ultimate end, *viz.*, universal healthcare insurance coverage.

Defendants' assertions that the Individual Mandate was meant to implement

ancillary provisions of the ACA governing the sale and content of healthcare insurance policies, DMSJ 19–20, are insupportable. Those provisions, requiring insurance companies to cover preexisting conditions, regulating premiums, and eliminating lifetime benefit caps, are actually "essential" to implementing the mandate. They make it possible for those with preexisting or chronic conditions to secure and maintain the healthcare insurance coverage *the Individual Mandate requires*.

The ACA's structure, text, and legislative history make this plain. The only congressional findings in Title I of the ACA relate to the "individual responsibility" provision, and those findings state that the provision's primary purpose is to "achieve near-universal coverage." ACA § 1501(a)(2)(D). *Cf.* Remarks by the President at Signing of the Health Insurance Reform Bill, http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill, March 23, 2010 ("And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care."). The other findings, citing other provisions of the Act, are subsidiary to this goal. Indeed, it was the Individual Mandate that Congress identified as "essential" to its legislative purpose, not the two lesser provisions – "guaranteed issue" and "community rating" – that Defendants now assert the Individual Mandate serves to implement. DMSJ 20–21.

This reflects a reality that Defendants do not seriously challenge. With or without the Individual Mandate, "guaranteed issue" and "community rating" still could be

implemented in some fashion as effective commercial regulations.[13] Defendants do not even allege that either provision would operate less effectively or be more difficult to administer in the absence of a mandate, but merely that the lack of a mandate would "amplify incentives" for individuals to engage in cost-shifting. DMSJ 20–21.[14] However, this is a direct consequence *not* of anyone's failure to have insurance, but of Congress's own legislative actions. Absent the mandate, the insurance provisions would not achieve Congress's actual goal of guaranteeing universal healthcare coverage. But that ultimate political goal, however laudatory, is not a legitimate end "within the scope of the constitution" to which the Necessary and Proper Clause may be applied. *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 421).

Upholding the Individual Mandate as "essential" to the ACA's insurance regulations would license Congress to create and expand its own regulatory power through the simple expedient of legislating in such a manner as to create its own "necessity," as a means to obtain sufficient power to achieve its true object. This is the very antithesis of a limiting principle: congressional authority would be restrained only where Congress does not act in the context of a broad regulatory scheme. Under that approach, where Congress does enact a broad regulatory scheme, even one whose goals

[13] This stands in marked contrast, for example, to the situation in *Raich*, where the central provision of the Controlled Substances Act – *viz.*, the prohibition of the production, transport, distribution, etc., of dangerous drugs – would have been rendered wholly inoperative in many instances without the ability to reach intrastate activity.

[14] This point is indistinguishable from the argument rejected in *Lopez* that Congress may "regulate any activity that it found was related to the economic productivity of individual citizens." 514 U.S. at 564. Potentially any action or inaction may affect individuals' incentives; were that alone sufficient to support federal regulation, it would be "difficult to perceive any limitation on federal power." *Id.*

are beyond the reach of its enumerated powers, it would face no limits.

In fact, the Individual Mandate is precisely the type of "evasive legislation" – provisions attached to other legislation (however broad or narrow) as a means of regulating beyond what the commerce power otherwise would support, *see Raich*, 545 U.S. at 46-47 (O'Connor J., dissenting) – which the *Raich* Court acknowledged to be a potential danger, but which it did not find to be present in that case. *See id.* at 25 n.34 ("there is no suggestion that the CSA constitutes the type of 'evasive' legislation the dissent fears, nor could such an argument plausibly be made."). The mandate cannot be sustained as "necessary" or "essential" to the ACA's insurance reforms.

3. The Mandate Is Too Remote from the Insurance Regulations It Supposedly Supports

Even if the mandate were designed to support the ACA's insurance provisions, it would fail. Defendants rest their "economic activity" theory on presumed participation in the market for healthcare services, *not* the market for healthcare insurance that Congress purported to regulate with the Individual Mandate. However, as explained by one of Defendants' own authorities, "[a] common feature of several myths [about healthcare in America] is the conflation of health, health care and health insurance. The three are surely connected, but they are not the same." Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions about U.S. Health Insurance*, 27 Health Affairs w533 (2008) (DMSJ, Ex. 6). Thus, "[u]ninsured Americans who are sick pose a very different set of problems. They need health care, not health insurance. Insurance is about reducing uncertainty in spending. It is impossible to 'insure' against an adverse event that has already happened." *Id.* at w534.

Even if every American were a constant "participant" in the market for healthcare *services*, and surely they are not, that would not make them participants in the healthcare *insurance* market. Indeed, Congress itself sought to justify the Individual Mandate as a means of bringing individuals into the latter market, not to regulate their consumption of services in the former market. *See* ACA §§ 1501(a)(2)(G) ("[b]y significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals"), 1501(a)(2)(H) ("[b]y significantly increasing health insurance coverage and the size of purchasing pools ... the requirement, together with the other provisions of the Act, will significantly reduce administrative costs and lower health insurance premiums").

Thus, any market participation by those subject to the Individual Mandate is at least once removed from Congress's purported regulatory target, the healthcare insurance market. In fact, the mandate is yet several more steps removed from the insurance market regulations which it supposedly supports. Defendants and Congress claim that the mandate will reduce the dangers of "market timing" and "cost-shifting," which are exacerbated by the ACA's new rules on preexisting conditions and lifetime benefit caps. This claim, however, is based upon exactly the type of attenuated chain of effects that was rejected by the *Lopez* Court. *Lopez*, 514 U.S. at 567. *See also Comstock*, 130 U.S. at 1963 (links between challenged statute "and an enumerated power are not too attenuated."). Here, the mandate's support for the ACA's insurance regulations necessarily posits that: (1) everyone will consume healthcare services; (2) some persons

who can afford healthcare insurance will not buy it, to save money; (3) some significant percentage of these persons, when they do fall ill, will not pay for the healthcare services they consume; (4) providers will seek to shift these costs to insurers, and by extension to the healthcare insurance market in general, because the ACA requires insurers to take all comers; (5) requiring all individuals to have healthcare insurance will avoid such cost-shifting sufficiently to reduce premiums. *See* DMSJ at 19-25. This is the sort of reasoning that the *Lopez* Court rejected, and the same result must obtain here.[15]

D. That No Previous Congress Believed the Commerce Power To Support Enactment of Individual Mandates Negates Such a Power's Existence

For more than two hundred years, Congress has understood and accepted the fundamental limits on the commerce power. Before passage of the ACA, no Congress ever had required individual Americans to buy a particular good or service as a supposed regulation of "commerce."[16] Although a statute's novelty does not establish its unconstitutionality, the Court has made clear that the "'absence of power' to do something c[an] be inferred because Congress ha[s] never made an attempt to exercise

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[15] Given the integrated and interrelated nature of the modern market economy, both at the national and even global levels, under the Defendants' logic it would be possible to conflate all manner of markets for the purpose of determining whether an activity being regulated is reachable under the commerce power. This approach, which is insusceptible of any meaningful limiting principle, would contravene the teaching of *Lopez* and *Raich*, in which the Court recognized that intrastate activities only can be regulated if they are not too remote from the interstate activities at issue.

[16] This most certainly was not the case in *Wickard v. Filburn*, as Defendants incorrectly suggest. DMSJ at 29. Filburn only was subject to congressional regulation *because he was voluntarily engaged in the business of wheat farming*. He could have avoided regulation by cultivating some other, unregulated crop to meet his needs. The Individual Mandate offers no such choice.

that power before." Mem Op. at 64-65 (citing *Printz v. United States*, 521 U.S. 898, 905, 907-908, 918 (1997)).[17] The *Printz* Court's statement that if "earlier Congresses avoided use of this highly attractive power, we would have reason to believe that the power was thought not to exist," *Printz*, 521 U.S. at 905, is particularly instructive.

The power to require directly that all Americans obtain a particular good or service, including insurance, might be attractive from Congress's perspective. Yet, for generations, in seeking to achieve various political, economic, and social goals through the commerce power, Congress instead has taken care to restrict itself to utilizing indirect regulations to achieve its ends. It purposely has linked regulations to economic activities in or affecting interstate commerce, even though its broader goals often could have been achieved more directly through a mandate on businesses or individuals.[18]

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[17] According to the Congressional Budget Office ("CBO"), a congressional agency with "the primary duty and function" of advising Congress on "bills authorizing or providing new budget authority," 2 U.S.C. § 602(a), an individual healthcare insurance mandate is unprecedented in two respects: "First, it would impose a duty on individuals as members of society. Second, it would require people to purchase a specific service that would be heavily regulated by the federal government." Robert Hartman & Paul Van de Water, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance*, CBO Memo. Aug. 1994, at 1. Similarly, the Congressional Research Service ("CRS"), a congressional agency charged with "determining the advisability of enacting [legislative] proposals," 2 U.S.C. § 166(d)(1), found it "a novel issue whether Congress may use [the Commerce Clause] to require an individual to purchase a good or service." Jennifer Staman & Cynthia Brougher, *Requiring Individuals To Obtain Health Insurance: A Constitutional Analysis*, CRS Report No. R40725, July 2009, at 3. *See id.* at 6 (distinguishing a mandate from Congress's usual use of its commerce power to regulate those "who *voluntarily* take part in some type of economic *activity*") (emphasis added).

[18] *See, e.g.,* 29 U.S.C. § 212(a) (prohibition on child labor implemented as limitation on shipment of goods in interstate commerce); 15 U.S.C. § 78i(a) (prohibiting "manipulation of security prices" when accomplished "by the use of the mails or any means or instrumentality of interstate commerce" or through a national securities exchange); 21 U.S.C. § 62 (making it unlawful "to ship or deliver for shipment in interstate or foreign

There is no better example of this practice – manifesting Congress's respect for the commerce power's limitations – than the National Flood Insurance Program ("NFIP"), which Defendants incorrectly cite as an example of another individual mandate requiring persons to obtain insurance. DMSJ at 30. According to the United States Geological Survey, "[d]uring the 20th century, floods were the number-one natural disaster in the United States in terms of number of lives lost and property damage. They can occur at any time of the year, in any part of the country, and at any time of the day or night." Charles A. Perry, *Significant Floods in the United States During the 20th Century – USGS Measures a Century of Floods,* Mar. 2000, http://ks.water.usgs.gov/pubs/fact-sheets/fs.024-00.html (last visited Nov. 23, 2010). Economic damage from flooding runs well into the billions of dollars annually. National Weather Service, *Flood Losses: Compilation of Flood Loss Statistics*, http://www.nws.noaa.gov/hic/flood_stats/Flood_loss_time_series.shtml (last visited Nov. 23, 2010).

Congress has acted to ameliorate these losses through the NFIP, established under the National Flood Insurance Act of 1968, as amended, 42 U.S.C. § 4001, *et seq*. As Defendants state, the NFIP includes a "mandate" that certain individuals have flood insurance. However, despite the severe and national scope of the problem, Congress did not impose an individual insurance mandate that all Americans, or all homeowners, or even anyone living in a flood plain must obey on pain of penalty. Acting within its constitutional parameters, Congress required flood insurance *only* as a *condition* of

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commerce" any "filled milk"); 21 U.S.C. § 331(a) (central provision of the Food, Drug and Cosmetic Act prohibiting the "introduction or delivery for introduction into interstate commerce of any food, drug, device, tobacco product, or cosmetic that is adulterated or misbranded").

securing and maintaining a mortgage *from a federally-regulated financial institution*. 42 U.S.C. §4012a(a)(b) & (e). The requirement does not apply to property owners who do not have such mortgages or to anyone else who lives under threat of flooding.

To the extent that Congress wanted to keep those without flood insurance from imposing costs on others, a far more direct regulation would have been simply to require all individuals living in a flood plane to have insurance. But the 90th Congress took the indirect and constitutionally-permissible route, because it understood that the commerce power permits regulation of interstate commerce – including mortgage lending – but not of individual Americans, even if they live in a flood plain. As the *Printz* Court stated, "two centuries of apparent congressional avoidance of the practice ... tends to negate the existence of the congressional power asserted here." *Printz,* 521 U.S. at 918.

II. THE ACA'S MEDICAID TRANSFORMATION IS UNCONSTITUTIONAL

Defendants' request for summary judgment on Count Four of the Amended Complaint likewise must be denied. Defendants fail to controvert any of the key facts upon which Count Four is based. Indeed, Defendants do not contest:

- that the Medicaid program is long-established and critically relied upon by tens of millions of poor and needy residents in the States;
- that the ACA fundamentally transforms Medicaid, and the States' partnership role and financial obligations in the program, in precisely the ways that Plaintiffs contend;
- that Congress, in creating the ACA's very structure, presupposes and depends on the States' inability to walk away from Medicaid;

- that no transitional mechanism exists under law to facilitate an orderly withdrawal from Medicaid by a State so as to avoid jeopardizing the lives and welfare of millions of its poorest and neediest residents; and
- that States' withdrawal from Medicaid would mean the loss of funding from the Nation's single largest grant program – a whopping $251 billion per year comprising 40 percent of all federal outlays to States and averaging 20 percent of States' budgets – while State citizens still would be required through payment of taxes to fund Medicaid programs of participating States.

Instead of meeting the thrust of Plaintiffs' position, Defendants point to how much more the federal government will be spending under the ACA. However, this response is legally irrelevant to whether the Act unlawfully coerces and commandeers the States. Congress simply does not possess an untethered ability to transform Medicaid in any manner that it wishes. If anything, enhanced federal funding underscores the ever-increasing power that the ACA exerts over the States: the more the federal government spends, the more it taxes resources away from residents and businesses of the States; the greater the diversion of local resources to Washington, D.C., the greater the States' need for subsidies from the federal government; and the greater the States' need for such subsidies, the stronger the federal government's position to dictate coercive and arbitrary conditions which the States must accept.[19]

[19] As this Court noted, "if the state plaintiffs make the decision to opt out of Medicaid, federal funds taken from their citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to states that have agreed to continue participating in the program." Mem. Op. at 56.

Defendants then fantastically assert that the Act will *save* the States money. Defendants rely primarily on a pre-ACA report of the President's Council of Economic Advisers ("'CEA"). However, as Plaintiffs' responsive Declarations show, that report is based on demonstrably invalid assumptions, which probably explains why *none* of the federal agencies tasked with assessing the Act's impact – including the CBO, which estimated the net costs to the States to be in excess of $20 billion – even cited it. *See* PRSOMF ¶ 48. Significantly, the CEA report, like Defendants themselves, completely ignores the Act's new requirement that the States (but not the federal government) be responsible for the *provision* of healthcare services, an obligation that could lead to tremendous costs for the States, particularly in light of projected shortages of providers for Medicaid recipients. It also ignores ACA provisions that prohibit States from tightening eligibility requirements – a typical but important way for States to control costs – and, for the first time, prevents them from reducing huge *optional* outlays (comprising 60 percent of States' Medicaid spending). *See* Anna Sommers, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories*, Kaiser Comm'n on Medicaid & the Uninsured, June 2005, at 11.

Moreover, the entire question of whether the States' costs might to some extent be offset by collateral savings is legally irrelevant: regardless, the ACA represents a substantial departure from the Medicaid partnership between the federal government and the States, and imposes heavy new burdens that the States cannot avoid.

Once the preposterous assertion that the ACA will save the States money is swept aside, Defendants are left with rearguing the justiciability of Plaintiffs' claim, an issue already resolved against them by this Court.

Finally, Defendants fail to address that the ACA's overhaul of Medicaid violates every restriction on Congress's spending power under Article I of the Constitution.

A. Defendants Cannot Dispute the ACA's Significant Alterations to Medicaid

As the Supreme Court noted in *Harris v. McRae*, 448 U.S. 297, 301, 308 (1980), "[t]he Medicaid program was created … for the purpose of providing federal financial assistance to States that *choose to reimburse* certain costs of medical treatment *for needy persons*." (Emphasis added.)

The ACA undoes every critical characteristic of the Medicaid partnership between the States and the federal government. Medicaid was enacted to address healthcare needs of the *poor and needy*, but the ACA expands eligibility to all persons whose income is up to 38 percent *above* the federal poverty line. Medicaid was limited to *reimbursing* needy persons' healthcare expenses, but the Act now requires the States (but not the federal government) to *provide* medical care. ACA § 2304.[20] These undeniable changes go far beyond the original Medicaid partnership. In effect, they constitute a new Medicaid regime, imposed in top-down fashion – the antithesis of partnership.

[20] The *Harris* Court, as if anticipating the ACA, warned of federal overreaching of the Medicaid partnership: "Title XIX was designed as a cooperative program of shared financial responsibility, *not as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund*." 448 U.S. at 309 (emphasis added).

It is no answer to say that the States, in entering into their pre-ACA Medicaid programs, agreed that the federal government could amend the programs. The federal-state Medicaid partnership agreement did not afford plenary power to the federal government to make *any* Medicaid revision that it wished irrespective of the States' expectations, or to bully the States with threats to remove them from the program for failing to accept transformative and harmful new conditions. Prior amendments to the States' Medicaid programs involved comparatively modest refinements of eligibility criteria (or optional revisions – again, *60 percent* of Medicaid spending being optional) for the benefit of the poor, young, aged, and infirm populations. Judicial decisions cited by Defendants (DMSJ at 48) have upheld such amendments as they comport with the basic nature of the partnership that States voluntarily entered. The States could foresee these amendments, which were consistent with the well-settled Spending Clause requirement that Congress must not condition funding to the States on ambiguous terms. *See South Dakota v. Dole*, 483 U.S. 203, 207-08 (1987). But those earlier changes are a far cry from the ACA's blanket departure from needy eligibility categories and its substitution of broad income-based eligibility 38 percent above the federal poverty line.

Moreover, the States could not have foreseen that Congress would impose on them the burden of being responsible for providing healthcare services *themselves* rather than merely reimbursing the healthcare costs of the needy. This change exposes the States to massive costs, burdens, and potential liabilities to which they never agreed, and which Congress has refused to share. As Plaintiffs have shown, PMSJ [Doc. 80-1] at 41 n.41 & 42 n.42, a serious shortage of Medicaid providers is projected. This shortage, on

top of ACA's imposed new burden that that the States be responsible for the provision of services, will put the States in a terrible dilemma: either increase their Medicaid expenditures drastically to attract sufficient numbers of providers, or face potentially catastrophic liabilities for widespread failures to furnish needed healthcare services in timely fashion. While this ACA imposition alone could bankrupt the States, none of the government agencies and outside organizations assessing the ACA's overall costs has, to Plaintiffs' knowledge, even ventured to assign a dollar figure for this burden. So glaring an omission surely is not the result of the cost being trivially small; if anything, the omission reflects that the cost is so gargantuan as to defy estimation – which probably explains why the federal government has refused to be co-responsible for this burden.

In addition, while the Medicaid partnership afforded States wide discretion to control various aspects of their programs, the ACA removes this and imposes maintenance-of-effort requirements that punish States by locking in their previously-optional higher spending levels and freezing those levels in place for a prescribed period. *See* Sommers, *supra* (more than 60 percent of Medicaid spending is optional). As with the other changes imposed by the ACA, this elimination of discretion – an important factor to controlling program costs – was not reasonably foreseeable by the States.

In effect, Congress has scuttled the existing Medicaid program in favor of a new program that is vastly different and specially designed to facilitate the ACA's goal of near-universal coverage – a goal wholly distinct from the previous Medicaid objective of helping the needy. Thus, the ACA greatly widens the Medicaid "door" so that a much-enlarged population can pass through it to comply with the Individual Mandate.

The ACA makes no provision for States to continue their participation in Medicaid under its pre-ACA terms. Nor does the ACA make any provision for States either to exit Medicaid or to effect a safe transition from Medicaid that would protect their needy residents. Thus, Congress seeks to use its funding hold over the existing Medicaid partnership to force the States to accept the new Medicaid regime and its obligations and costs. This Hobson's choice is an abuse of Congress's spending power.

B. The ACA's Transformation of Medicaid Harms the Plaintiff States' Budgets and Sovereignty

Defendants argue that the ACA is not coercive because the increased State spending required by the ACA will be small compared to federal spending levels and because the ACA is broadly beneficial. Mem. at 39. Defendants understate the magnitude of the States' Medicaid obligations under the ACA, which they modestly calculate to be 1.4 percent over existing baseline projections, while wholly ignoring (1) the well-documented fiscal emergency in States arising from those same baseline projections of spiraling State Medicaid obligations that threaten their fiscal viability; (2) the dangerous expansion of State obligations that requires States to be responsible for the provision of healthcare services, with a virtually certain massive increase in liability; and (3) the elimination of States' flexibility under Medicaid to control their costs. In sum, the ACA's transformation of Medicaid stands to run State budgets off the proverbial cliff.

1. Plaintiffs' Coercion Claim Is Not Undermined By Increased Federal Spending on Medicaid under the ACA

Defendants boast of substantial increases in federal spending associated with the ACA's Medicaid program in comparison to the relatively "small outlays" required of the

States, DMSJ at 39, but this is no defense to Plaintiff States' coercion claim. As noted above, the States depend on the return to them, through Medicaid grants, of the vast resources taken from their citizens and businesses by the federal government. That the federal government is *increasing* Medicaid outlays under the ACA – on condition that the States accept the new Medicaid regime or lose all Medicaid funding – only strengthens the conclusion that the federal government has made the States an offer they cannot refuse. If ever there were to be a "financial inducement offered by Congress … [that] pass[es] the point at which 'pressure turns into compulsion[,]'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)), *this is it*. The ACA surely represents the very danger that prompted Justice O'Connor, in her dissent in *Dole*, to warn that the "vast financial resources of the Federal Government" could permit Congress under the guise of the Spending Clause "'to tear down the barriers [and] to invade the states' jurisdiction….'" 483 U.S. at 217 (O'Connor, J., dissenting) (quoting *United States v. Butler*, 297 U.S. 1, 78 (1936)).

Protection against undue coercion is especially warranted here, where participation in the ACA's program will harm the Plaintiff States in serious ways. While Defendants belittle the increase in State spending required by the ACA ("just 1.4 percent" over current projected spending, DMSJ at 40), this increase – on top of already spiraling Medicaid spending obligations – threatens the States' fiscal viability and ability to fund other significant priorities. Even before the ACA, Medicaid imperiled State budgets with substantial increased spending projections at an annual average rate of 7.9 percent through 2019 (and 9.9% just in 2009). CMS, *National Health Expenditure Projections*

2009-2019, https://www.cms.gov/NationalHealthExpendData/downloads/ proj2009.pdf, at 1-2 (last visited Nov. 23, 2010). Federal Medicaid officials concede that "[h]igh and increasing Medicaid spending clearly leaves states less able to fund other state priorities." CMS, *Medicaid Spending Projected to Rise Much Faster Than the Economy*, http://www.hhs.gov/news/press/2008pres/10/20081017a.html (last visited Nov. 23, 2010) (quoting Acting CMS Administrator Kerry Weems).

Other federal authorities simultaneously acknowledge the terrible condition of State finances and their large projected budget gaps (currently up to 41 percent in Fiscal Year 2010).[21] Already-increasing Medicaid obligations combined with then-current Medicaid and healthcare induced budget stress left Federal Reserve Chairman Ben Bernanke to conclude that "State budgets will probably remain under substantial pressure for a while, leaving governors and legislatures a difficult juggling act as they try to maintain essential services while meeting their budgetary obligations." Pl.App. Ex. 34 (Bd. of Governors of the Federal Reserve System, *Challenges for the Economy and State Governments*, Aug. 2, 2010) at 6; *see also The Long-Term Budget Outlook*, CBO, June 2010 ("CBO Budget Outlook") at 27, available at http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf (last visited Nov. 23, 2010) ("state governments – which pay a large share of Medicaid's costs and have considerable influence on those costs – will need to reduce spending growth in order to

[21] Pl.App. Ex. 35 (*Policies for Increasing Economic Growth and Employment in 2010 and 2011,* Cong. Budget Off., Jan. 2010) at 13, 16 (figure 4); *see also State Fiscal Conditions & Medicaid,* Kaiser Comm'n, http://www.kff.org/medicaid/upload/7580-06.pdf (including current gaps and those already closed by states, budget shortfalls total $350 billion for 2010 and 2011).

balance their budgets"). According to the federal Government Accountability Office ("GAO"), States must immediately control Medicaid and healthcare costs for many years ahead to prevent operating deficits – calculated to be $9.9 *trillion* from 2009 to 2058 – and persistently cut costs "for each and every year going forward [to achieve] equivalent to a 12.3 percent reduction in state and local government current expenditures." Pl.App. Ex. 38 (*State and Local Governments: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs* (GAO-10-899), GAO, July 2010) at 6.[22] Chairman Bernanke has counseled States to "intensively review the effectiveness of all programs and be willing to make significant changes to deliver necessary services … [which is] especially important in the case of health programs, where costs are growing the most quickly." Bernanke, *supra*, at 12.[23]

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[22] *See also* Pl.App. Ex. 37 (*State and Local Governments' Fiscal Outlook (GAO-10-358)*, March 2010) at 8-9:

> Because most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations suggest [that] these governments will need to make substantial policy changes to avoid growing fiscal imbalances.… The primary driver of fiscal challenges for the state and local government sector continues to be … state and local expenditures on Medicaid and the cost of health insurance for state and local retirees and employees.

[23] Another recent report sums up the States' Medicaid fiscal dilemma as follows:

> Medicaid, the $360 billion a year federal-state health program that serves more than 60 million low-income Americans, has emerged as a central factor in the states' budget and financial crisis. But an even more severe crisis looms ahead, given the steady rise in health care costs, together with higher, recession-induced demand for Medicaid benefits, and the end of $103 billion in federal stimulus aid to states by mid-2011.
>
> In the absence of major reforms and a robust economic recovery, the potential consequences of the growing state Medicaid squeeze are substantial, experts say. States may slide deeper into the red, affecting

Thus, even before Congress looked to increase State Medicaid funding by 1.4 percent under the ACA (according to Defendants' modest projections), the States faced a grim fiscal outlook under baseline projections that will continue to require swift and drastic State action. *See* Kaiser Comm'n on Medicaid & the Uninsured, *State Fiscal Conditions & Medicaid,* Feb. 2010, at 3, http://www.kff.org/medicaid/upload/7580-06.pdf (last visited Nov. 23, 2010) ("nearly every state implemented at least one new Medicaid policy to control spending in FY 2009 and 2010 … [and m]id-way through FY 2010, 44 states indicated that they were likely to or there was a possibility of additional Medicaid cuts beyond those planned at the beginning of the state fiscal year"). With State finances in critical condition, and a widespread existing need for States to *cut* their Medicaid costs, Defendants' attempt to pass off increased State outlays as "relatively small" and insignificant is disingenuous: "It's like living in a parallel universe, … [o]n the one hand, we have federal partners talking about expansion of this program. And at the state level, we're looking at a program that we can't sustain." Janet Adamy, *Medicaid Stalemate Tests Cash-Strapped States*, Wall. St. J., July 13, 2010 (quoting a Medicaid official in one of the Plaintiff States).

> bond ratings and making it more difficult for them to borrow. Deep cuts in kindergarten through grade 12 and higher education spending could make recent teacher layoffs seem relatively trivial. Sharp state tax and user fee increases may be inevitable. Even some anti-big government conservative governors may be forced to seek additional federal aid. And health care for the poor — the basic function of Medicaid — may suffer.

Andrew L. Yarrow, *State Budget Crises Mount as Medicaid Rolls Soar,* The Fiscal Times, Sept. 8, 2010, *available* at http://www.kaiserhealthnews.org/Stories/2010/September/08/FT-states-budget-crisis-medicaid.aspx (last visited Nov. 23, 2010).

In sum, the ACA's Medicaid program stands to harm the Plaintiff States substantially, despite Defendants' contention that it offers a good deal to the States.

2. Increases in State Spending Will Not Be Offset By New Savings Under the ACA

Defendants next make incredible claims that State costs will be more than offset by savings under the ACA. They would have this Court discount documented costs to the States from the ACA (which Defendant do not deny, see DSOMF ¶¶ 40, 47) in favor of indefinite and inaccurate projections of countervailing State savings drawn from an unsworn analysis from the Executive Office of the President, Council of Economic Advisers, that was released months prior to anyone knowing the ACA's final terms, during the intense campaign for passage of a comprehensive healthcare bill.[24]

As the sworn declarations from several Plaintiff States' Medicaid agency representatives show, the CEA report's analysis has serious flaws that render Defendants' savings claims not only unestablished, but unbelievable. PRSOMF at ¶¶ 48-57. For instance, Defendants boldly assert that "Florida alone is projected to save $377 million per year." DMSJ at 41. But the CEA report upon which Defendants exclusively rely actually shows that virtually none of the "savings" applies to the State of Florida:

- Most of the claimed "savings" – more than $256 million – applies to local governments only, not to the budget of the State of Florida: $187 million for Miami-Dade County, $82 million for Hillsborough County, $660,000 in Duval County, and $5.6 million relating to inter-county reimbursements. *See* CEA report at 24, 26. The State of Florida will not see *any* savings from these local

[24] CEA Chair Christina Romer deemed herself "the most passionate person for health care reform in the entire White House." *Romer on Health Care Costs: "The Nightmare Scenario is Getting Closer*," June 2, 2009, http://blogs.abcnews.com/politicalpunch/2009/06/romer-on-health-care-costs-the-nightmare-scenario-is-getting-closer.html (last visited Nov. 23, 2010).

government programs financed through local taxes, though the State may see cost *increases* as persons switch out of such local programs to Medicaid.

- The CEA report's "Hidden Tax" ($102 million) figure (pp. 6, 24) erroneously assumes that the healthcare bill will eliminate uncompensated care altogether. This figure is fatally flawed as Defendants admit, for instance, that 55 percent of current uninsured persons under the federal poverty line will remain uninsured in Florida, DMSJ at 39, and 21 million nationally. *See Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act*, CBO, April 22, 2010. The CEA report also bases this estimate on costs borne by both State *and local* governments, and so it is inaccurate in any event to attribute the full $102 million savings estimate to the State of Florida alone.

See Pl.Supp.App. Exs. 4 (Further Dudek Decl.) & 5 (Pridgeon Decl.). The CEA report also understates costs by relying on the increase for Medicaid eligibility to 133 percent above the poverty line, when in fact the ACA as amended raises that criterion to 138 percent, thereby adding millions more Medicaid recipients to States' rolls. *See* Pl.Supp.App. Ex. 1 (Chaumont Further Decl.) ¶ 17 & Ex. 3 (Damler Decl.) at ¶ 11.

In addition, the CEA report forecasts State savings (of $117 million) that "may come" from the Children's Health Insurance Program. CEA report at 24-25. But Florida, for example, already has taken State CHIP-related savings projections into account in its own forecast (*see* Pl.App. Ex. 1 (Dudek Decl.) at ¶ 20, wherein Florida estimates the ACA will cost it more than $1 billion annually by 2018-19; *see also* Pl.Supp.App. Ex. 1 (Chaumont Further Decl.) at ¶ 13).

It is no wonder that the CEA report is not even cited by government agencies in their assessments of projected costs from the ACA. *See, e.g.*, Pl.App. Ex. 39 (Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act,"* Centers for Medicare & Medicaid Servs., April 22, 2010); Pl.App. Ex. 36 (*Variation in*

Analyses of PPACA's Fiscal Impact on States, Cong. Res. Serv., Sept. 8, 2010) at tbl 2; Def.App. Ex. 32 (CBO Letter to Speaker Pelosi).

Moreover, Defendants' "savings" projections entirely overlook other potentially significant additional costs to the States – most dramatically, costs and liabilities from being required to provide (rather than reimburse the cost of) healthcare services. However, CMS has indicated that it is "probable initially" that there will be fewer healthcare providers accepting Medicaid patients:

> [I]t is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years. … For now we believe that consideration should be given the potential consequences of a significant increase in demand for health care meeting a relatively fixed supply of health care providers and services.

Pl.App. Ex. 39 (*Estimated Financial Effects of the [ACA]*, CMS) at 20. The ACA shifts this problem entirely to the States for them to bear the costs and legal consequences of a programmatic failure that the federal government thoroughly foresees. This, added to the general projection of a looming serious doctor shortage, puts the States in an untenable dilemma: either (1) increase their Medicaid outlays substantially in the hope of attracting sufficient numbers of providers to furnish all needed services to Medicaid recipients, or (2) face the consequences for failing to meet this ACA requirement, including potential massive liabilities and loss of Medicaid funding. Any claim of net "savings" that ignores such catastrophic consequences is seriously misleading and should be disregarded.

Beyond all of these categories overlooked by Defendants, CRS recognizes that the ACA could increase States' costs in the following areas:

- State requirement to maintain existing Medicaid and CHIP eligibility levels (MOE) for adults until exchanges are fully operational (presumably CY 2014) and

for children through 2019 as a condition of receiving federal matching funds for Medicaid expenditures;

- State requirement to improve outreach, streamline enrollment, and coordinate with CHIP and proposed exchanges that may increase applications and enrollment among those previously eligible but not yet enrolled, as well as increase administrative costs in the short run (*see* PRSOMF ¶ 41 n.3 & n.4);

- Federal requirement to reduce Medicaid disproportionate share hospital (DSH) allotments. While the healthcare reform law is designed to lower the number of low income patients and patients whose care otherwise would be funded in part by DSH payments to hospitals treating such patients, the ACA's requirement to reduce DSH payments going forward may necessitate increased outlays by States to shore up hospitals against losses;

- Federal requirement to increase the amount of Medicaid drug rebates going to the federal government. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the HHS Secretary on behalf of states. Beginning January 1, 2010, with certain exceptions, the ACA increases the flat percentage used to calculate Medicaid's basic rebate by an amount that varies by drug class. The ACA also requires the Secretary to recover the additional funds States received from drug manufacturers due to increases in the basic Medicaid rebates (some of which were previously retained by States).

Pl.App. Ex. 36 (*Variation in Analyses*, CRS) at 4-5; see also PSOMF ¶¶ 15, 21, 24-27.

In sum, the notion that the States could achieve net savings under the ACA is both unsupported and preposterous. *See* PRSOMF ¶¶ 57-58 (disputing two other papers that Defendants cite in passing in DMSJ at 41 n.12). No credible assessment of the ACA's projected impact forecasts any such thing. And, as noted, none places a dollar value on the ACA's requirement that States provide healthcare services under the new Medicaid regime, or on the harm to State budgets from the ACA's maintenance-of-effort provisions that remove their ability to cut costs by revising (formerly) optional eligibility categories.

Moreover, even if the States were projected to achieve collateral savings, those savings would in no way lessen the coercion and commandeering of which Plaintiff

States complain, because they still would be required to do Congress's bidding, and to incur costs and liabilities under the ACA's new Medicaid regime, as noted above.

C. Plaintiffs States' Coercion Claim Is Justiciable and Fit for Judicial Resolution in Plaintiffs' Favor

Their other contentions unavailing, Defendants rehash their argument that coercion claims are nonjusticiable. However, this Court already has analyzed Defendants' argument and the viability of the coercion doctrine, and concluded that the Plaintiff States' claim is not foreclosed in this circuit or by Supreme Court precedent:

> If the Supreme Court meant what it said in *Dole* and *Steward Machine Co.* (and I must presume that it did), there is a line somewhere between mere pressure and impermissible coercion. The reluctance of some circuits to deal with this issue because of the potential legal and factual complexities is not entitled to a great deal of weight, because courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court. … [T]he plaintiffs have stated a "plausible" claim in this circuit.

Mem.Op. at 56-57.

Moreover, as recently as 1999, the Supreme Court acknowledged the viability of coercion claims based on financial inducement in a case that closely divided on the question of whether a federal act unlawfully could "coerce" a State to waive its sovereign immunity as a condition of pursuing lawful activity. *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999). Although *College Savings Bank* did not involve financial inducement, the Court noted that where Congress threatens to withhold "substantial" funds unless a State agrees to its conditions, "'the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* (quoting *Dole*, 483 U.S. at 211, and

Machine, 301 U.S. at 590). Thus, this Court again should reject Defendants' argument that coercion claims are nonjusticiable.

Defendants add a divide-and-conquer argument that the ACA-transformed Medicaid program might be coercive for some States, but not for others. DMSJ at 44-45. Of course, federal bullying of less-populated States (Defendants attempt to peel off, for instance, Alaska and Wyoming) with the "single largest Federal grant-in-aid program to the States, accounting for over 40 percent of all Federal grants to States"[25] still would constitute unlawful coercion. Even though the nature and scope of Medicaid programs and funding differ according to States' policies, sizes, and priorities, federal support for the Medicaid programs in all States is quite substantial, amounting to hundreds of millions or billions of dollars annually in State budgets and averaging more than *20 percent* of total State spending nationally.[26]

Moreover, it is no answer that State Medicaid spending levels in the Plaintiff States fall at different places on a "substantial impact continuum" from 8.4 percent of Alaska's total State spending to more than 30 percent of Pennsylvania's. In either case, and for all States in-between, Congress's threat to withhold significant percentages of State funding easily meets and exceeds the unlawful financial inducement threshold. That is, the threat to exclude citizens in any State from this enormous program –

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[25] Bipartisan Comm'n on the Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005); *see also* Pl.App. Exs. 32-33 (CMS letters to Arizona).

[26] *See* http://www.statehealthfacts.org/comparereport.jsp?rep=45&cat=17 (last visited Nov. 23, 2010); http://www.hhs.gov/recovery/statefunds.html (last visited Nov. 23, 2010) (more than $15 billion additional federal Medicaid dollars were distributed to the States in 2009).

consuming some seven percent of *all* federal outlays ($251 billion in 2010)[27] and funded with federal taxes paid by citizens from all States – would constitute unlawful coercion even for a State that spends comparatively less of its budget on Medicaid.

Regardless of which State is considered, federal Medicaid funding dwarfs the $4 million in highway grant funds at stake in *Dole* that the Supreme Court found to be merely "mild encouragement." 483 U.S. at 211. Indeed, the Medicaid program dangles total funding that is *twelve times higher* than the amounts that Justice Breyer and three other justices considered "compelling and oppressive" in *College Savings Bank.* 527 U.S. at 697 (Breyer J. dissenting) (suggesting coercion with respect to $20 and $21 billion programs). Thus, whatever quibbles Defendants have as to exactly how large a lesser financial inducement must be to trigger application of the coercion doctrine need not be resolved here, because Medicaid is not a marginal spending program. The ACA coerces States with the single largest federal grant-in-aid program to the States.

The unprecedented financial coercion apparent in the ACA's unilaterally transformed Medicaid program, combined with the absence of a defined mechanism for States to exit the program (discussed further below), establishes the Plaintiff States' coercion claim and forecloses summary judgment for the Defendants.

D. <u>The ACA's Medicaid Program Is Unlawfully Coercive</u>

Defendants' final argument also essentially restates their view that coercion claims are nonjusticiable, citing to those circuit court decisions that have so ruled. DMSJ at 47-50. Defendants assert that the size of a federal grant does not matter, the proportion

[27] *CBO Budget Outlook* at 30; Citizen's Guide to the Federal Budget, http://www.gpoaccess.gov/usbudget/fy01/guide02.html (last visited Nov. 23, 2010).

of federal funding does not matter, and the importance of the federal grant does not matter; in sum, and contrary to this Court's prior ruling, they believe that a State cannot establish an unlawful coercion claim on any set of facts. Defendants' citation to *Steward Machine* does not help their argument, as that case did not involve direct and drastic consequences for State budgets, but only encouragement for States to administer an unemployment compensation program funded by taxes on employers. Moreover, *Steward Machine* involved a wholly new program and decision for the States, and not Congress's strategic transformation of a large and long-established program to force States into making a destructive Hobson's choice affecting millions of needy recipients.

Here, Plaintiff States must either accept the ACA's radically changed Medicaid, or (1) forgo billions of dollars annually, which the federal government collects from State taxpayers and then returns as Medicaid funds to the States; and (2) risk the welfare of their most vulnerable citizens, and the continuing vitality of their healthcare infrastructure, by attempting to opt out of Medicaid without any defined transition process or established programmatic alternative. No federal program besides Medicaid funds healthcare services for the States' poorest and neediest residents, and the States plainly are unable to establish, fund, and implement a Medicaid-like replacement program, much less to do so immediately to safeguard needy Medicaid recipients dropped by the federal program.

The prospect of losing these vast sums coerces Plaintiff States not only because of the unprecedented funding levels at stake, but also because Congress has deprived Plaintiff States of the ability to replace their current Medicaid programs. As noted, the

Court has identified this critical aspect of the ACA's program: the federal government "has little money except through taxpayers, who almost exclusively reside within the states," and if federal Medicaid funds are withheld the tax revenues collected in the States who opt out will be diverted to other, more compliant States. Mem.Op. at 56.

Plaintiff States cannot make up this shortfall. In particular, they cannot simply raise State taxes as Defendants suggest in citing *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989).[28] DMSJ at 47. In Florida, as an example, State tax collections in 2009 totaled less than $32 billion, whereas IRS collections from Florida were $110 billion.[29] In 2010, Florida will spend more than $20 billion on Medicaid, toward which the federal government is expected to return to Florida more than $12 billion.[30] For Florida now to opt out of Medicaid and itself provide the same $20 billion in benefits would consume *more than half* of its tax revenues (up from 19 percent currently), not counting the significant costs associated with administering such a program.[31]

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[28] Indeed, federal policymakers suggest that raising State tax increases would only compound the States' fiscal dilemma, and provided federal aid for the *very purpose* of keeping the States from raising taxes. *See* Christina D. Romer, *Back to a Better Normal: Unemployment and Growth in the Wake of the Great Recession*, Council of Economic Advisors, April 17, 2010 at 9, *available* at http://www.whitehouse.gov/sites/default/files/rss_viewer/back_to_a_better_normal.pdf (last visited Nov. 23, 2010).

[29] *See* http://www.census.gov/govs/statetax/0910flstax.html (last visited Nov. 23, 2010); http://www.irs.gov/taxstats/article/0,,id=206488,00.html (last visited Nov. 23, 2010).

[30] *See* Pl.App. Ex. 4 (Leznoff Decl.).

[31] CMS requested $725 million for 2011 to administer Medicaid and other programs. *See* CMS, *Justification of Estimates for Appropriations Comm.*, FY 2011, at 28-29, https://www.cms.gov/PerformanceBudget/Downloads/CMSFY11CJ.pdf (last visited Nov. 23, 2010).

Replacing these revenues would necessitate unfathomable State tax increases (more than 50 percent in Florida), from populations which must continue to pay federal taxes. This alone sets this case far apart from any previous coercion claims rejected by various circuit courts, and exceeds even the "compelling and oppressive" scenarios outlined by Justice Breyer in *College Savings Bank*.[32] Moreover, there are both practical and legal constraints on Florida's ability to raise additional revenue of the magnitude required to replace federal Medicaid payments to the State. *See* Pl.App. Exs. 4 (Leznoff Decl.) & 5 (Watkins Decl.).

Unlike any of the cases cited by the Defendants, these weighty and incontestable constraints unlawfully force the Plaintiff States to participate in the ACA's new Medicaid regime, and to assume billions of dollars of unaffordable new costs and other costly responsibilities against their will. In subjecting Plaintiff States to this unprecedented Hobson's choice, Congress has exceeded its Article I powers and violated fundamental principles of federalism, the Ninth and Tenth Amendments, and the Guarantee Clause. The illusory "choice" offered to the States goes far beyond the point at which persuasion becomes coercion under *Dole*. Congress, having made captives of the States,

[32] Nor is debt-financing of recurring expenses a sustainable option for enabling States that opt out of Medicaid to provide comparable services without federal funding. "Most states have already borrowed as much as they can under their own budget rules and will probably remain up against those limits during the next few years." Pl.App. Ex. 35_ (CBO, *Policies for Increasing Economic Growth and Employment in 2010 and 2011,* Jan. 2010) at 13, 16 (figure 4). As Federal Reserve Chairman Ben S. Bernanke notes: "the balanced budget rules followed by 49 of the 50 states … provide important discipline and are a key reason that states have not built up long-term debt burdens comparable to those of many national governments." Pl.App. Ex. 34 (*Challenges for the Economy and State Governments*) at 6.

impermissibly commandeers Plaintiff States into funding and administering a new federal program contrary to *New York v. United States*, 505 U.S. 144 (1992), and *Printz*.

E. The ACA Violates All Five *Dole* Spending Clause Restrictions

Moreover, imposition of the ACA's Medicaid regime on the States violates all restrictions on Congress's Article I, section 8 spending power under *Dole*, 483 U.S. at 207-08.

First, the Hobson's choice imposed on the States – to give way to federal dictates or attempt to withdraw from Medicaid – cannot reasonably be characterized as furthering the general welfare. Either way, the States' ability to aid the poor will be impaired, because their participation in the ACA-altered Medicaid program threatens to leave them without the resources to provide medical care to indigents, while withdrawal would leave no federally-funded indigent care program at all, and the States alone cannot afford to offer Medicaid-level benefits.

Second, Congress did not condition Medicaid funds on unambiguous terms: the ACA's sweeping changes could not reasonably have been foreseen by the States when they started their Medicaid programs or later chose to add costlier optional elements.

Third, the ACA's altered and expanded conditions – a critical component of a new universal healthcare regime – change the fundamental purpose for which Medicaid was established: *viz.*, as a means to aid the States' poorest residents.

Fourth, the ACA violates State sovereignty and federalism principles, as shown.

Fifth, the ACA unlawfully coerces the States, for all the reasons discussed above.

Because the ACA exceeds every restriction on Congress's spending power, Defendants' claim for summary judgment in their favor on Count Four must be denied.

III. THE ACA MUST BE STRUCK DOWN IN ITS ENTIRETY

The Individual Mandate cannot be severed from the ACA's other provisions. It is the centerpiece of Congress's effort to provide for universal national healthcare insurance, DMTD [Doc. 55-1] at 5, 7, 46-48, and Congress clearly would not have enacted the ACA without the mandate. Based on the statute's text, history, and legislative purpose, without the Individual Mandate Congress "would have preferred ... no statute at all[.]" *Ayotte v. Planned Parenthood of No. New England*, 546 U.S. 320, 330 (2006).

And, of course, it is highly significant that Congress, in crafting one of the most sweeping federal statutes in decades, did not include a severability clause in the ACA. Although the absence of such a provision does not bind the Court, *see, e.g., Alabama Power Co. v. U.S. Dept. of Energy*, 307 F.3d 1300, 1308 (11th Cir. 2002), in this case it strongly suggests that Congress would not "have preferred what is left" of the Act without the Individual Mandate. *See Ayotte*, 546 U.S. at 330. *Cf. Brockett v. Spokane Arcades*, 472 U.S. 491, 506 (1985) (citing severability clause as an important factor favoring partial rather than facial invalidation of statute).

Likewise, the ACA's Medicaid regime constitutes one of four "doors" through which an individual may pass to obtain qualified coverage in order to comply with the Individual Mandate. Hence, the Medicaid regime is essential to the Act's architecture: remove it, and there is no provision for the Nation's tens of millions of poor and needy

persons to comply with the mandate. Because the Act cannot function independent of its Medicaid provisions, those provisions cannot be severed. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684-86 (1987); *Hill v. Wallace*, 259 U.S. 44, 70 (1922). It is therefore unreasonable to infer that Congress would have passed the ACA in the absence of its Medicaid provisions. *See Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 330-32 (2006). Consequently, the unconstitutionality of the Act's Medicaid regime requires that the entire ACA be struck down.

Conclusion

For all the reasons stated above, Defendants' motion for summary judgment should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 23rd day of November, 2010, a copy of the foregoing Plaintiffs' Memorandum in Opposition to Defendants' Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

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