STATE OF FLORIDA et al v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES et al Doc. 126

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

STATE OF FLORIDA, by and through BILL McCOLLUM, *et al.*,

Plaintiffs,

v.

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

Defendants.

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

BRIEF OF *AMICI CURIAE* STATE LEGISLATORS*
IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Our Constitution creates a vibrant system of federalism that gives broad power to the federal government to act in circumstances in which a national solution is necessary or appropriate, while reserving a significant role for the States to craft innovative policy solutions that showcase the diversity of America's people, places, and ideas. Far from violating state sovereignty or the principles of federalism in our Constitution, the Patient Protection and Affordable Care Act (ACA or "the Act") reflects the federal-state partnership at its best. *Amici* State Legislators believe the Act is constitutional and is good for their States and constituents, and they are working hard in their States to implement the Act in a timely and effective manner.

While Plaintiffs claim in this lawsuit to represent the people of their respective States and the interests of the States in general, the State legislators appearing herein as *amici*—many from the same States as the Plaintiffs—do not agree with the Plaintiffs' legal arguments or position. Health care reform was imperative for Americans, as well as for their State and local governments. The ever-rising costs of and limited access to insurance coverage and health care have severely stressed the budgets of State governments and American families, and literally result in tens of thousands of deaths each year.

The Plaintiffs claim that the ACA "greatly alters the federal-State relationship, to the detriment of the Plaintiff States, with respect to Medicaid programs, their insurance regulatory role, and healthcare coverage generally." Amended Complaint ¶ 42. As a

threshold matter, the federal reform law does not ignore or denigrate the important partnership role played by the States in protecting the health and security of their citizens; to the contrary, the Act capitalizes upon much of the innovation and good policy that has been modeled by State and local governments.

In addition, the Plaintiffs' claim that the Act's Medicaid-related provisions are unconstitutional under the Ninth and Tenth Amendments, *e.g.* Am. Compl. ¶¶ 83-86, is fundamentally flawed in light of the fact that States continue to have the option to opt out of Medicaid and its various requirements altogether. The Plaintiffs acknowledge that they do not want to end their participation in the federal-State Medicaid program, because to do so "would desert millions of their residents, leaving them without access to the healthcare services they have depended on for decades under Medicaid." Am. Compl. ¶ 66. This is absolutely true—residents in *Amici* State Legislators' States have come to appreciate and rely upon Medicaid. But the Constitution allows the federal government to structure or condition federal funds and programs in a certain way, allowing States to choose whether to participate and accept those conditions, or not. It is well-established that "Congress may attach conditions on the receipt of federal funds." *South Dakota v. Dole*, 483 U.S. 203, 206 (1987).

The Plaintiffs' Medicaid claims appear to seek a judicial "do-over" on the Act, trying to get this Court to craft a health care reform law that is more to the Plaintiffs' liking. *See, e.g.*, Pls.' Mem. Supp. Summ. J. 26 (praising the Medicaid program of the 1960s and 1970s as "the hallmark of cooperative federalism" but objecting to the "new"

Medicaid standards). That is an effort that belongs in the political arena, not the courts. As this Court noted, Congress "expressly reserved the right to alter and amend the [Medicaid] program." Slip Op. at 51 (citing 42 U.S.C. § 1304). And, under the Spending Clause, U.S. CONST. art. I, section 8, Congress may "fix the terms on which it shall disburse federal money to the States," *New York v. United States*, 505 U.S. 144, 158 (1992), and may "condition[] receipt of federal moneys upon compliance . . . with federal statutory and administrative directives," *Dole*, 483 U.S. at 206 (citations omitted). State leaders must now choose whether to comply with the new Medicaid requirements, or opt out of the program altogether. Plaintiffs cannot expect the Court to absolve them of this choice by picking and choosing among parts of the federal Medicaid program. This choice may be "politically painful," but it is not "unconstitutionally 'coercive.'" *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000). Indeed, a number of States are in fact considering "dropping out of Medicaid." Emily Ramshaw & Marilyn Serafini, *Battle Lines Drawn Over Medicaid in Texas*, N.Y. TIMES, Nov. 16, 2010.

The Constitution's federalism provisions authorize, rather than prohibit, placing these questions of political leadership and priorities in the hands of State officials and the residents they serve. *See New York*, 505 U.S. at 168. The people's representatives in Congress and the Executive Branch, supported by *Amici* State Legislators, have passed a health care reform law that expands coverage, cuts costs, and ensures health insurance security for millions of Americans. The law sets a minimum national floor of coverage and protection while allowing States significant options—including whether to continue in the Medicaid program, whether and in what manner a state insurance exchange should

be established, and even whether to seek a waiver from the federal program and try to build a better health care system. The Plaintiffs cannot properly be allowed to avoid political accountability to their constituents by asking the Court to do what they cannot—or will not—do through the legislative and political processes.

Because *Amici* State Legislators believe that the Patient Protection and Affordable Care Act is within Congress's constitutional powers and is fully consonant with the federalism provisions of the Constitution, *Amici* support the Defendants' Motion for Summary Judgment and respectfully ask that it be granted.

ARGUMENT

I. The Affordable Care Act Respects the Federal-State Partnership on Health Care and Preserves Constitutional Federalism.

The federal system in the United States is founded on a Constitution that gives broad power to the federal government to act when a national solution is necessary or preferable, while preserving the role of State and local governments to create policy responsive to local needs and customs. *See* Akhil Reed Amar, AMERICA'S CONSTITUTION: A BIOGRAPHY 108 (2005) (noting that the delegates to the Constitutional Convention instructed the Committee of Detail, which drafted the enumerated powers of Congress in Article I, that Congress should have authority to "legislate in all Cases for the general Interests of the Union, and also in those Cases to which the States are separately incompetent") (citing 2 MAX FARRAND ED., THE RECORDS OF THE FEDERAL CONVENTION OF 1787 (rev. ed. 1966), at 131-32). *See generally* Federalist No. 2 (John Jay), in THE FEDERALIST PAPERS (Clinton Rossiter ed., 1999). States historically have

been leaders in policy innovations that better protect their citizens, resources, and environment. *See* Exec. Order on Federalism No. 13132, 64 Fed. Reg. 43255, § 2(e) (Aug. 4, 1999) ("States possess unique authorities, qualities, and abilities to meet the needs of the people and should function as laboratories of democracy.") The States have a long history of leadership on health care reform—indeed, the Patient Protection and Affordable Care Act incorporated the valuable lessons learned from the experience of health care reform practices by our State and local governments, and preserves the role of our States as laboratories of democracy, for example, by giving States considerable policy flexibility. There is no basis in the Constitution for Plaintiffs' claims that the Act "violates the constitutional principles of federalism and dual sovereignty on which this Nation was founded." Am. Compl. ¶ 86. To the contrary, the Act addresses an issue of dire national importance, while allowing States room to innovate and shape aspects of health care reform to reflect the needs and preferences of their communities.

For example, States have the discretion to form their own insurance exchange or join with other States to form a regional exchange. *See* ACA § 1321, 42 U.S.C. 18041. A State may also choose not to operate an exchange at all, in which case the federal government will administer a statewide insurance exchange for the benefit of the State's citizens. *Id.* at § 1321(c). While States must provide the opportunity to buy four levels of health care plans on the exchange—platinum, gold, silver, and bronze plans, at declining expense—they have significant discretion with respect to other aspects of the plans. *See* ACA § 1331, 42 U.S.C. 18051.

States can also set up their own programs—with or without a minimum coverage provision, or with a public option—under what has been called the Empowering States to be Innovative provision. ACA § 1332, 42 U.S.C. 18052. States can obtain a waiver from the federal government if they set up a system that meets the coverage and cost containment requirements in the Act. *Id.* This allows for the diversity and innovation that is the hallmark of the States. *See generally New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (observing that, under our federalism, "a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country").

The benefits of national health care reform for States and their citizens will be substantial, in part because the size of the problem with health care is so great. Despite the fact that Americans spent an estimated 2.5 trillion dollars on health care in 2009, more than 45 million Americans do not have health insurance. Pub. L. No. 111-148, §§ 1501(a)(2)(B), 10106(a), 124 Stat. 119, 907 (2010); *see also* CONG. BUDGET OFFICE, 2008 KEY ISSUES IN ANALYZING MAJOR HEALTH PROPOSALS 11 (Dec. 2008); CONG. BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK 21-22 (June 2009). Individuals and families face disastrous personal and financial consequences when they find themselves with serious medical problems and no insurance. *See* Pub. L. No. 111-148, §§ 1501(a)(2)(G), 10106(a) (noting that 62% of all personal bankruptcies are precipitated in part by medical expenses); Institute of Medicine, AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 58, 78-79, 80 (2009) (observing that uninsured people have a higher likelihood of being hospitalized and of dying

prematurely, and of experiencing greater limitations on their quality of life when compared to insured people). In addition, when the uninsured receive medical assistance, the uncompensated health care costs, which were $43 billion in 2008, are borne by federal, State and local governments, as well as by those who pay for insurance and health care providers. Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a).

The Act will help address these serious problems. The number of uninsured Americans will drop by approximately 32 million by 2019, and the average insurance premium paid by individuals and families in the individual and small-group markets will be reduced. Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives 9 (March 20, 2010); CONG. BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 23-25 (Nov. 30, 2009). This substantial number of newly covered individuals is achieved in large part by the Act's requirement that the States expand Medicaid to all non-elderly individuals with incomes up to 133 percent of the poverty line, or about $29,000 for a family of four. The federal government will assume 96% percent of the costs of this expansion over the next ten years, and, in its first five years, the Medicaid expansion will add just 1.25% to what States were projected to spend on Medicaid over that same period in the absence of reform. JANUARY ANGELES & MATTHEW BROADUS, FEDERAL GOVERNMENT WILL PICK UP NEARLY ALL COSTS OF HEALTH REFORM'S MEDICAID EXPANSION (Center on Budget and Policy Priorities, April 20, 2010). Expanding health care coverage will also substantially lower the cost to States for uncompensated care. *See* Council of Economic

Advisors, *The Impact of Health Insurance Reform on State and Local Governments* (Sept. 15, 2009).[1]

The federal-State partnership on health care that has already helped so many Americans through the federal-State Medicaid program is appropriately respected in the new health care reform law. While the Act responds to a pressing, national health care crisis, it allows key policy flexibility for the States, reflecting the best of our federalism. In addition, the requirements of the Act and the funding it provides States will benefit both strained government budgets and the lives of each State's residents. The Plaintiffs' claim that the Act violates constitutional principles federalism is meritless.

II. The Plaintiffs' Constitutional Challenge to the Act's Medicaid Expansion Is Groundless and Should Be Rejected.

The Plaintiffs allege that the Act's Medicaid-related provisions are unconstitutional because they amount to "coercion and commandeering." Am. Compl. ¶¶ 83-86. This claim fails because the States cannot be "coerced" into doing anything with respect to Medicaid—Medicaid is a voluntary federal-State partnership, which the States could opt out of if their leaders and citizens so desired, avoiding the Act's new requirements for expanded Medicaid coverage. Recognizing that Medicaid is a valued program that provides crucial access to care for millions of the Plaintiffs' constituents,

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[1] Moreover, there are additional benefits and costs recovered in the long-term, which include having a more robust and healthy workforce and better quality of care overall. When communities have a large uninsured population, even insured people will have decreased access to adequate health care. Institute of Medicine, AMERICA'S UNINSURED CRISIS 108-09. States also will be better positioned to attract and maintain hospitals. Medical research facilities may increase the attention paid to diseases and health problems affecting traditionally uninsured populations, because health insurance would assure financial return. In addition, health care will become less costly for the insured, affording those families greater spending power. *See* Carole Keeton Strayhorn (Texas Comptroller of Public Account), *The Uninsured: A Hidden Burden on Texas Employers and Communities*, Apr. 2005.

however, the Plaintiffs attempt a novel argument that tries to keep what they like about the program, including substantial federal funding, while avoiding the Act's new requirements, which they oppose. *See* Am. Compl. ¶ 66. This claim presents neither a claim of coercion nor of commandeering and should be denied.

Medicaid is "a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). It is, and always has been, a voluntary program for the States. *Id.* Medicaid enables States to receive a significant amount of federal aid in exchange for the States' establishing public health insurance programs for the poor, subject to minimum federal requirements, *e.g.*, 42 U.S.C. § 1396(a)(10)(A)(I) (requiring the States to extend medical coverage to "categorically needy" individuals). Congress expressly reserved the right to amend Medicaid, 42 U.S.C. § 1304, and has done so many times. *E.g.*, Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (requiring participating States to extend Medicaid to recipients of Supplemental Security Income); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989) (requiring States to expand Medicaid coverage to pregnant women and children under six-years-old, subject to certain income limits). States do not have to participate in Medicaid at all; Arizona did not join Medicaid until 1982. *See* Management of Arizona Medicaid Waiver: Hearings before the Subcomm. on Health & the Environment of the House Comm. on Energy & Commerce, 98th Cong., 2d Sess. 222 (1984).

The federal government currently pays on average 57% of the cost of a State's Medicaid program, allowing millions of people to get health insurance, a benefit that relieves the pressure that uninsured citizens place on State and family budgets. *See* ANGELES & BROADUS, at 2. The program covers a broad array of services and supports that serve the needs of low-income people (especially children and people with disabilities), who are more likely than people with higher incomes to be in fair or poor health. *Id.* After adjusting for the health status of recipients, Medicaid is also significantly less costly, on a per-beneficiary basis, than private insurance, largely due to its lower provider rates and administrative costs. *Id.*

Starting on January 1, 2014, the Act will expand Medicaid eligibility to individuals under 65 with incomes below 133% of the poverty line, expanding coverage to millions of people who could otherwise not afford health insurance. To ease the burden on the States, the federal government will assume 100% of the Medicaid costs of covering newly eligible individuals for the first three years; federal support will phase down slightly over the following several years, so that for 2020 and all subsequent years, the federal government will be responsible for 90% of the costs of covering these individuals. ANGELES & BROADUS, at 3. The States' share of the cost of the Medicaid expansion will be approximately $20 billion. This represents just a 1.25% increase over the $1.6 trillion that States were projected to spend on Medicaid, for fewer people, over the same time frame, in the absence of health care reform. *Id.* at 4. At the same time, the Congressional Budget Office estimates that the Medicaid changes will result in $434 billion in extra Medicaid and Children's Health Insurance Program money flowing to the

States between 2010 and 2019. *Amici* State Legislators believe this represents a good deal for their constituents and their States.

Plaintiffs appear to argue that this is *too* good a deal: one that they can't refuse. But it has been true for several decades, at least, that while "State participation in Medicaid is entirely voluntary, [] it is in a state's interest to participate since otherwise the state and its localities would, as a practical matter, have to provide many of the same services without the financial assistance of the federal government." Elizabeth Anderson, *Administering Health Care: Lessons from the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215, 220 (1994).

The Supreme Court has made clear that the temptation to accept federal funds does not amount to coercion. *South Dakota v. Dole*, 483 U.S. 203, 212 (1987). The Constitution allows the federal government to structure or condition federal funds and programs in a certain way, allowing States to choose whether to participate and accept those conditions, or not. It is well-established that "Congress may attach conditions on the receipt of federal funds." *Id.* at 206. When the Supreme Court validated the Social Security Act, for example, it recognized that to hold that "motive or temptation [on the part of a State to comply with a condition attached to a federal appropriation grant] is equivalent to coercion is to plunge the law in endless difficulty." *Steward Machine Co. v. Davis*, 301 U.S. 548, 589-90 (1937).

Congress's spending power enables it to condition the disbursement of federal funds on States' meeting particular criteria. This extends to conditions that require States

to fund programs or otherwise spend state funds for particular purposes. *See King v. Smith*, 392 U.S. 309 (1968) (upholding statute that conditioned federal matching funds on certain State actions, including the expenditure of State funds, because, if Alabama wanted to continue receiving the federal funds, it had to abide by the conditions). If the State finds the conditions too onerous, it may simply refuse the federal funds. *See Oklahoma v. United States Civil Service Comm'n*, 330 U.S. 127 (1947) (upholding the Hatch Act, which required that any employee of a state highway commission [financed in whole or part with federal funds] must be removed from office if he/she was found to be engaging in political activities, because the federal government may attach conditions to disbursement of funds, and because the employee and the State have the right to refuse funds).

Similarly, the voluntary nature of Medicaid renders the Plaintiffs' "commandeering" claim regarding the Act's expansion of Medicaid coverage to over 16 million more low-income adults and children groundless. The Supreme Court's "anti-commandeering" jurisprudence holds that the federal government "may not compel the States to enact or administer a federal regulatory program." *Printz v. United States*, 521 U.S. 898, 926 (1997); *New York v. United States*, 505 U.S. 144, 188 (1992). But again, the States are not compelled to enact or administer the Medicaid expansion required by the Act—they can opt out of Medicaid altogether. Losing federally-funded Medicaid would surely be a bitter pill to swallow for Plaintiffs and their constituents, but Congress may constitutionally "hold out incentives to the states as a method of influencing a state's policy choices." *New York*, 505 U.S. at 166; *see also id.* at 167 ("Where the recipient of

federal funds is a State, as is not unusual today, the conditions attached to the funds by Congress may influence a State's legislative choices.") So long as Congress merely "encourages state regulation rather than compelling it, state governments remain responsive to the local electorate's preferences; state officials remain accountable to the people." *Id.* at 168.

Indeed, while Plaintiffs dramatically suggest that opting out of Medicaid could have "severe consequences for poor Americans" similar to those that resulted from another "health-related event," Hurricane Katrina, Pls.' Mem. Supp. S. J. at 36 n.34, other State leaders (even some who also represent States of the Plaintiffs) have expressed their view that rejecting the Affordable Care Act's Medicaid expansion would be in their State's best interest. For example, Texas Governor Rick Perry recently told Fox News that opting out of the Medicaid program could save the state and federal government $40 billion each over six years: "We think in Texas over the next six years that we could take and find a private insurance solution and better serve our people, put more people under coverage." Althea Fung, *Texas Considers Opting Out of Medicaid*, NATIONAL JOURNAL, Nov. 15, 2010. *See also* Emily Ramshaw & Marilyn Serafini, *Battle Lines Drawn Over Medicaid in Texas*, N.Y. TIMES, Nov. 16, 2010 (noting that "the idea of dropping out of Medicaid is on the table in Texas and roughly a dozen other states, including Alabama, Mississippi, Washington and Wyoming"). This may not be a wise policy choice, but it is a *possible* choice—and one that demonstrates that States are not impermissibly "coerced" into remaining in the Medicaid program.

The decision State leaders face is clear: whether to take steps to implement the Act's expansion of Medicaid and work in partnership with the federal government to provide better health care for State residents, or to opt out of Medicaid altogether. Either of these choices is possible (although *Amici* State Legislators believe the first path is better for their States and their constituents). Accordingly, the political accountability concern that animates the Supreme Court's "anti-commandeering" jurisprudence cuts against Plaintiffs here. *New York*, 505 U.S. at 168 (explaining that, by allowing Congress to encourage State regulation but not expressly compel it, officials are still accountable to the people for their choices). If the Court were to allow Plaintiffs to use its "anticommandeering" claim to preserve the aspects of Medicaid they like—specifically, Medicaid prior to the passage of the Act, *see* Am. Compl. ¶¶ 39-41—while doing away with the expanded coverage requirements of the duly enacted health reform law, the political accountability concerns articulated by the Supreme Court in *New York* would not be served.

Congress established Medicaid in Title XIX of the Social Security Act of 1965; the States then had the option whether to jointly fund the program with the federal government, or not. Here, Congress has voted to expand Medicaid to help reduce the number of uninsured people by 32 million in the next ten years; States can again determine whether to continue working with the federal government in the Medicaid partnership, or not. In either case, the elected federal officials and the elected State leaders will be accountable for their choices. The Plaintiffs seek to avoid that accountability by asking the Court to invalidate the new conditions placed on Medicaid

funds while retaining the existing, popular portions of the program. Such an argument does not properly raise a claim of unconstitutional "commandeering" or "coercion" and should be rejected.

CONCLUSION

Amici State Legislators support the steps toward effective health care reform undertaken in the Patient Protection and Affordable Care Act and believe that the Act is fully constitutional. As State leaders who are actively working to implement and prepare for various requirements of the Act, *Amici* support the Defendants' Motion for Summary Judgment so that the States may continue their work with confidence, knowing that their implementation efforts will not be delayed or derailed by groundless constitutional challenges. *Amici* State Legislators respectfully submit that the Court should enter summary judgment in favor of the Defendants.

Dated: November 19, 2010

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CERTIFICATE OF SERVICE

I hereby certify that on November 19, 2010, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel of record.

Dated: November 19, 2010

/s/ Elizabeth B. Wydra
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