

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

STATE OF FLORIDA, by and through)
BILL McCOLLUM, ATTORNEY GENERAL)
OF THE STATE OF FLORIDA, *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 GOVERNORS TIM PAWLENTY AND DONALD L. CARCIERI
AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS’
MOTION FOR SUMMARY JUDGMENT**

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I.

INTEREST OF *AMICI*

As the Governors of Minnesota and Rhode Island, respectively, *amici* Tim Pawlenty and Donald L. Carcieri have a direct interest in this case. The Patient Protection and Affordable Care Act of 2010 (“ACA”) fundamentally transforms Medicaid and will effectively co-opt control over the States’ budgetary processes and legislative agendas, crowding out spending on other state priorities, including duties that are mandated by state constitutions.¹ Given their role in shaping and overseeing state budgets, the Governors have a vital stake in ensuring that basic limits on the federal government’s spending power are maintained.² One of those limits is that any conditions imposed by federal law must be clear, so that States may exercise their choice to accept or reject federal funds “knowingly, cognizant of the consequences of their participation.”³ On November 12, this Court granted the Governors leave to file their *amicus* brief (Docket # 108).

¹ *See, e.g.*, Minn. Const., Art. XIII, § 1 (state has “duty” to “establish a general and uniform system of public schools” that is “thorough and efficient”); Rhode Island Const., Art. XII (state has “duty” to “promote public schools and public libraries” to foster “diffusion of knowledge,” and to not “divert” education funds).

² *See, e.g.*, Rhode Island Const., Art. IX, § 15 (Governor “shall prepare and present” the state budget “to the general assembly”); Minn. Const., Art. IV, § 23 (line-item veto).

³ *South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

II.

ARGUMENT

The Affordable Care Act is Unconstitutionally Vague and Indefinite

A. The ACA's Ambiguity Renders It Illegitimate Under Spending-Clause Jurisprudence, Which Requires That Federal Conditions Be Clear and Definite Enough to Be Contractually Valid and Enforceable

As plaintiffs rightly note, the ACA “violates the principle that conditions on federal funds must be unambiguous, so as to ‘enable the states to exercise their choice knowingly, cognizant of the consequences of their participation.’”⁴ This is both because the ACA includes “vast potential liabilities that cannot even be projected as of now,” and because “the ACA’s sweeping changes could not reasonably have been foreseen by the states when they started their Medicaid programs.”⁵ As a result, the States could not have voluntarily and knowingly assumed the burdens and liabilities now imposed on them by the ACA.

Even looking at the ACA purely from the vantage point of the present, rather than when States began participating in Medicaid, the ACA is so ambiguous and indefinite that it is facially unconstitutional, as we explain below. This vagueness undermines political accountability and thus aggravates the ACA’s unduly coercive aspects, in violation of the Tenth Amendment.⁶

⁴ *Memorandum In Support of Plaintiffs’ Motion for Summary Judgment* at 36.

⁵ *Id.* at 42, 45.

⁶ *See New York v. United States*, 505 U.S. 144, 168 (1992) (Spending Clause legislation’s legitimacy is rooted in the fact that “where Congress encourages state regulation rather than compelling it, state governments remain responsive to the local electorate’s preferences; state officials remain accountable to the people.”; “Accountability is thus

The Supreme Court has repeatedly characterized legislation enacted pursuant to the spending power as “much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions.”⁷ “The legitimacy of Congress’ power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the contract.” *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

But even if States could choose to stop participating in the Medicaid program, the ACA is so vague that it does not – and cannot – allow the States “to exercise their choice knowingly, cognizant of the consequences of their participation.” *Dole*, 483 U.S. at 207 (quoting *Pennhurst*). The ACA fails to speak “unambiguously,” *Pennhurst*, 451 U.S. at 17, about how a State can opt out of Medicaid’s expansion, and what State compliance may mean if it opts in.

Because the States are not given a clear and informed choice between participation and non-participation, the Act lacks the hallmarks of contractual enforceability. *See, e.g., Matter of T & B General Contracting*, 833 F.2d 1455, 1459 (11th Cir. 1987) (“Without a meeting of the minds on all essential terms, no enforceable contract arises.”).⁸ The Act is indefinite in other key respects as well, so “we cannot fairly say that [a] State could make an informed choice.” *Pennhurst*,

diminished when, due to federal coercion, elected state officials cannot regulate in accordance with the views of the local electorate.”).

⁷ *Pennhurst*, 451 U.S. 1, 17 (1981); *see also Barnes v. Gorman*, 536 U.S. 181, 186 (2002); *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

⁸ *See also Association Ben. Services, Inc. v. Caremark RX, Inc.*, 493 F.3d 841, 850 (7th Cir. 2007); Restatement (Second) Contracts, § 33; *see Pennhurst*, 451 U.S. at 17 (must show states’ acceptance of “the terms of the contract”).

451 U.S. at 25. “There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it.”⁹

B. The ACA’s Complexity Accentuates Its Vagueness

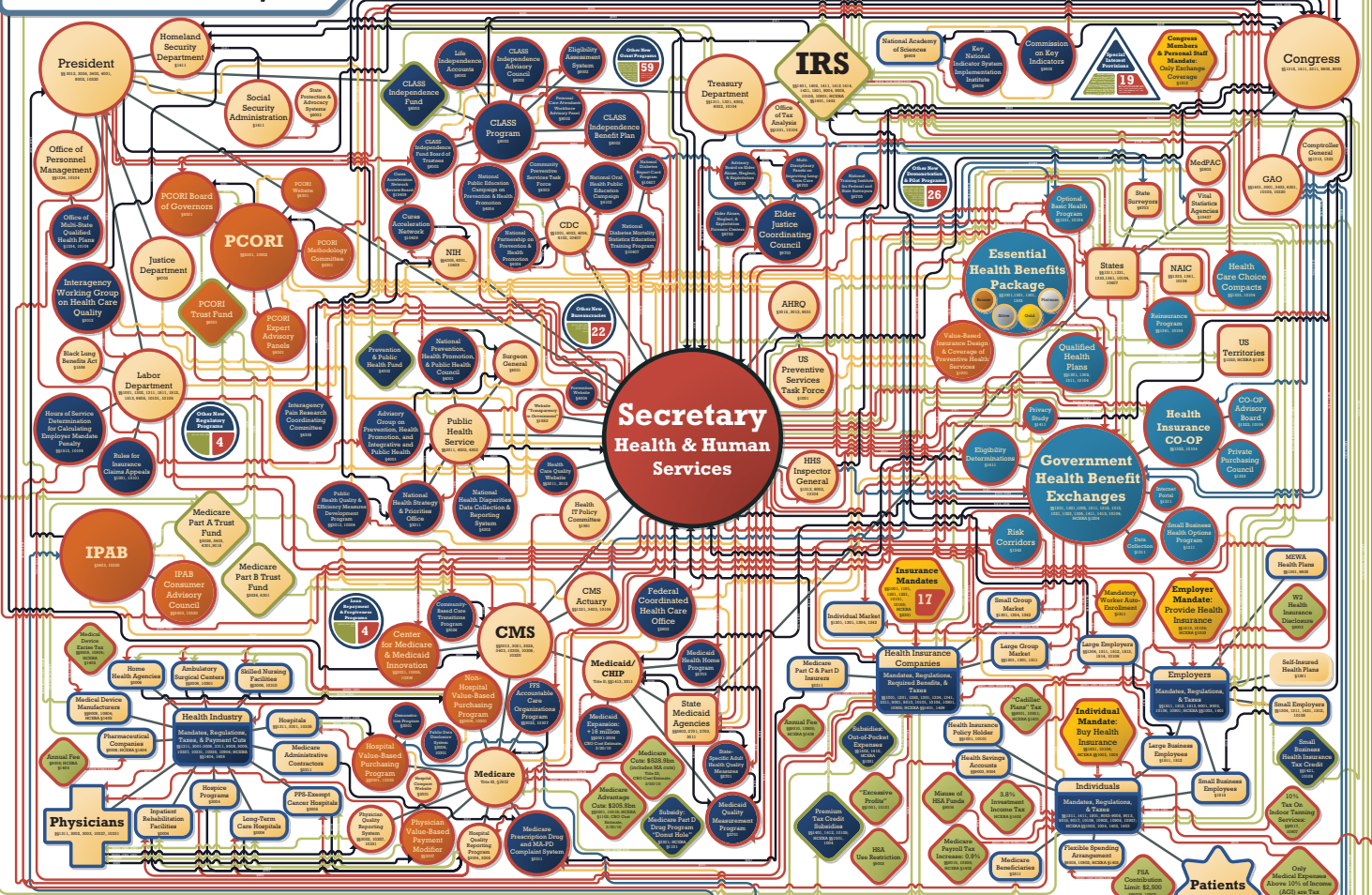
The ACA is so mammoth, its provisions are so complex, and its passage was so irregular that the federal attorneys who have spent the past eight months defending it cannot even clearly identify its length. (*See* Tr. at 8, Docket # 77). Its sheer complexity is aptly, but only partially, captured by the chart provided by minority staff of the Joint Economic Committee, which is found on the next page.¹⁰ (While that “chart displays a bewildering array of new government agencies, regulations and mandates,” the reality is even more complicated, since “committee analysts could not fit the entire health care bill on one chart. ‘This portrays only about one-third of the complexity of the final bill. It’s actually worse than this.’”¹¹

⁹ *Id.* at 17-18; *see Arlington Cent. Sch. Dist.*, 548 U.S. at 296; *Barnes*, 536 U.S. at 186.

¹⁰ *See* Joint Economic Committee, Republican Staff, *Your New Health Care System*, available at http://jec.senate.gov/republicans/public/?a=Files.Serve&File_id=5ee16e0f-6ee6-4643-980e-b4d5f1d7759a (visited Nov. 18, 2010); *Nebraska v. E.P.A.*, 331 F.3d 995, 998 n.3 (D.C. Cir. 2003) (taking judicial notice of agency materials on web); *Air Transport Ass’n v. U.S. Dep’t of Transp.*, 613 F.3d 206, 208 (D.C. Cir. 2010) (citing JEC report); *Livermore v. Heckler*, 743 F.2d 1396, 1403 (9th Cir. 1984) (report by JEC staff).

¹¹ *See* Joint Economic Committee Republicans, *America’s New Health Care System Revealed: Updated Chart Shows Obamacare’s Bewildering Complexity*, Committee News, Aug. 2, 2010 (quoting Rep. Brady), available at http://jec.senate.gov/republicans/public/index.cfm?p=CommitteeNews&ContentRecord_id=bb302d88-3d0d-4424-8e33-3c5d2578c2b0 (visited Nov. 18, 2010).

Your New Health Care System



New Government	Expanded Government	Private	New Relationships
<ul style="list-style-type: none"> ● Rationing Potential ● Involvement in Health Insurance Market ● Other Expansions ● Represents Bundles of Additional Entities 	<ul style="list-style-type: none"> ● Mandates ● Taxes & Monetary Fees/ Penalties/Cuts ● Trust Fund (Rationing Potential) ● Other New Trust Funds/ Monetary Benefits 	<ul style="list-style-type: none"> ● Private Entity with New Mandates/ Regulations/ Responsibilities ● Unchanged Private Entity ● Special Interest Provisions 	<ul style="list-style-type: none"> → Regulations/ Requirements/Mandates → Reporting Requirements → Oversight → Money Flows → Consultation/Advisory/ Info Sharing → Structural Connections (Includes Existing)

AGI: Adjusted Gross Income
 AHRQ: Agency for Healthcare Research and Quality
 CDC: Centers for Disease Control & Prevention
 CHIP: Children's Health Insurance Program
 CMS: Centers for Medicare & Medicaid Services
 FFS: Fee-for-Service
 FSA: Flexible Spending Arrangement
 GAO: Government Accountability Office
 HHS: Health, Care & Education Reconciliation Act
 HIR: Health & Human Services Department
 ISA: Health Savings Account
 IPAB: Independent Payment Advisory Board
 IRS: Internal Revenue Service
 MA-OP: Medicare Advantage Prescription Drug
 MedPAC: Medicare Payment Advisory Commission
 MIP: Medicare Inpatient Prospective Payment System
 SALOR: Executive Ancillary Linked Office Regional System
 MEPS: Multiple Employer Welfare Arrangement
 NAC: National Association of Insurance Commissioners
 NIH: National Institutes of Health
 PCORI: Patient-Centered Outcomes Research Institute
 PPS: Prospective Payment System

**Patient Protection & Affordable Care Act, P.L. 111-148;
 Health Care & Education Reconciliation Act, P.L. 111-152**
 Prepared by: Joint Economic Committee, Republican Staff
 Congressman Kevin Brady, Senior House Republican
 Senator Sam Brownback, Ranking Member

This enormous complexity accentuates its vagueness,¹² and makes it all but impossible to comprehend “from the perspective of a state official who is engaged in the process of deciding whether the State should accept [federal] funds and the obligations that go with those funds.” *Arlington Cent. Sch. Dist.*, 548 U.S. at 291. Thus, the Plaintiff States cannot be expected to “exercise their choice knowingly, cognizant of the consequences of their participation.” *Dole*, 483 U.S. at 207.

C. The ACA’s Vagueness Is Aggravated by the Vast Discretion and Virtual Blank Check It Gives to the Federal Officials Who Implement It

Even if the ACA’s text were fully understood, many of its requirements would ultimately be unknowable due to the unprecedented discretion granted to federal officials to implement key provisions. States, for example, will be required to “develop service systems” to provide long-term care that “allocate resources for services in a manner that is responsible to the changing needs and choices of beneficiaries” ACA § 2404(a). The substance of this vague mandate is delegated to the discretion of the Secretary of Health and Human Services. *Id.*

Similarly, states must provide individuals who are “newly eligible” for Medicaid with “benchmark” coverage. ACA § 2001(a)(2)(A). The substance of this mandate too is expressly delegated to the discretion of the Secretary. ACA §§ 2001(c)(3), 1302(a), (b). The Secretary is also empowered to determine, *inter alia*, state enrollment programs for Medicaid and CHIP, ACA § 1413(a), obstetric

¹² *Cheek v. U.S.*, 498 U.S. 192, 199-200 (1991) (“complexity” of statutes can make “it difficult for the average citizen to know and comprehend” their requirements); *Hope Clinic v. Ryan*, 195 F.3d 857, 866-67 (7th Cir. 1999), *vacated*, 530 U.S. 1271 (2000) (“complex” provisions can result in “unfair surprise”).

and smoking cessation services that must be provided by the states, ACA §§ 2301, 4107, and myriad data collection, evaluation, and reporting requirements that must be carried out by the states, *see, e.g.*, ACA §§ 2001(d)(1)(C), 2701, 2951.

The Secretary's vast discretion in implementing the ACA is illustrated by the more than 111 waivers that she has granted to employers whose health care plans were unable to satisfy the ACA's costly mandates.¹³ 1.2 million employees participate in the health plans that have already received waivers, and far more may be affected in the future.¹⁴ These waivers are not permanent, but last for only one year, adding further uncertainty.¹⁵ Moreover, there is no telling whether these *ad hoc* waivers, some of which were granted to politically-influential unions or businesses that supported the Administration and the ACA's passage,¹⁶ will be granted in the future to anyone else.¹⁷ If not, States may face enormous additional

¹³ *E.g.*, Reed Abelson, *Health Rules Are Waived More Often*, New York Times, Nov. 10, 2010, at B2 (available at www.nytimes.com/2010/11/10/health/policy/10waiver.html); Department of Health and Human Services, *Approved Applications for Waiver of the Annual Limits Requirements of the PHS Act Section 2711 As of Nov. 1, 2010*, available at http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html.

¹⁴ Abelson, *Health Rules Are Waived More Often*, N.Y. Times, Nov. 10, 2010, at B2.

¹⁵ Department of Health and Human Services, *Approved Applications for Waiver of the Annual Limits Requirements of the PHS Act Section 2711 As of Nov. 1, 2010*, available at http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html; *see* Abelson, *Health Rules Are Waived More Often*, N.Y. Times, Nov. 10, 2010, at B2.

¹⁶ *See* Michelle Malkin, Creators Syndicate, *Repeal Is the Ultimate Obamacare Waiver*, Washington Examiner, Nov. 18, 2010, at 43 (www.washingtonexaminer.com/opinion/columns/Repeal-is-the-ultimate-Obamacare-waiver-1595832-108685514.html).

¹⁷ *See* Michelle Malkin, *Waiver-Mania! The Ever-Expanding Obamacare Escapee List*, Nov. 14, 2010, at 10:26 a.m. (<http://michellemalkin.com/2010/11/14/waiver-mania-the-ever-expanding-obamacare-escapee-list/>) (arguing that Obama Administration is granting these "temporary" waivers not out of "compassion" or for consistent policy reasons, "but out of a panicked urgency to avoid a public relations disaster" of employers dumping large numbers of employees from health insurance shortly after passage of a law that the

costs, both from people who lose their employer-provided health insurance¹⁸ and end up on state-subsidized Medicaid programs, and, to a lesser extent, from the burdens it imposes on state employers (such as increased premium costs,¹⁹ and assessments imposed on employers for failure to offer the level of insurance mandated under ACA rules.) The Secretary’s vast discretion in writing and waiving ACA rules makes predicting these costs simply impossible, and makes it impossible for States to ascertain “the consequences of their participation,” *Dole*, 483 U.S. at 207. (Many rules that HHS is supposed to issue to implement the ACA’s vague requirements have not been issued yet, and either have no statutory deadline at all,²⁰ or have deadlines that have been flouted.²¹).

President promised would allow employees to keep their healthcare plan if they liked it); Reed Abelson, *Waivers Aim at Talk of Dropping Health Coverage*, New York Times, Oct. 7, 2010, at B1 (Obama Administration “tried to defuse stiffening resistance” to ACA through waivers, “as part of a broader strategic effort” to mollify critics “at a time when the midterm elections are looming”; White House official “acknowledged that the concessions given to companies and insurers reflected attempts to avoid having people lose their current coverage before the full law goes into effect”; “politics from state to state” cited as factor in debate over how stringently to enforce ACA mandates) (<http://www.nytimes.com/2010/10/07/business/07insure.html>)

¹⁸ In the absence of waivers, many employers will drop their health care plans. *See, e.g.*, Michelle Malkin, *Repeal Is the Ultimate Obamacare Waiver*, Washington Examiner, Nov. 18, 2010, at 43 (Fowler Packing Company “pursued an HHS waiver because their low-wage agricultural workers would have lost the[ir] basic coverage” absent a waiver, stripping “large numbers of workers” of “access to affordable coverage.”)

¹⁹ *See* Dr. Marc Siegel, *Obamacare Will Clog America’s Medical System*, USA Today, Oct. 19, 2010, at 9A (ACA pointlessly drives “up costs and premiums”) (available at www.usatoday.com/news/opinion/forum/2010-10-19-column19_ST_N.htm); J. P. Freire, *Dems Admit CEOs Were Right to Report Losses from Obamacare*, Wash. Examiner, April 27, 2010, at 1:24 p.m. (www.washingtonexaminer.com/opinion/blogs/beltway-confidential/dems-admit-ceos-were-right-to-report-losses-from-obamacare-92199744.html); *cf.* Don Surber, *Obamacare Leads to 47% Premium Hike*, Charleston Daily Mail, Oct. 16, 2010, 9 a.m. (<http://blogs.dailymail.com/donsurber/archives/22999>).

²⁰ *See* Congressional Research Service, *Deadlines for the Secretary of Health and Human Services in the Patient Protection and Affordable Care Act*, Oct. 1, 2010, at 1 (ACA rules

It also remains unclear whether many state employers will be able to benefit from the Act's "grandfather clause" provision protecting existing health plans from some of the ACA's costly mandates, as even the government's own estimates suggest.²² HHS has adopted regulations construing that provision so narrowly so that it arguably does not apply to the majority of employers. George Pantos, *Manage Rising Health Care Costs*, Atlanta Journal-Constitution, Sept. 20, 2010, at A21 ("The Obama administration has released its rules governing 'grandfathered' insurance plans. Those that qualify will remain legal . . . Those that don't will have to comply with costly new mandates. Throughout his campaign for health reform, the president vowed that he wouldn't disrupt Americans' existing policies. These rules are . . . so onerous, though, that most employers will find it impossible to follow them.") (found in Westlaw at 2010 WLNR 19387643).

As the Congressional Research Service notes, "Given the complexity of the health care system prior to PPACA, and the many changes generated by the new law, the impact on states will vary and will be difficult to estimate, even with the

"generally" have "flexible deadlines or no deadline at all") (available at http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=54103bf6-ae3a-47be-916e-72548ba34b5b).

²¹ See *id.* at 3-5 ("no public information found" for many rules that were due to be issued by now); Sen. Tom Coburn, *HHS Administrative Failure: HHS Failed to Meet a Third of Mandated Deadlines Under New Federal Health Care Law*, Oct. 4, 2010, available at http://coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=f6efel1e-39bc-4532-a586-d1ad0b608e80.

²² See *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act*, 75 Fed. Reg. 34538, 34552 (June 17, 2010) (employers relinquishing grandfather status estimated at between 33% to 69% for all employers, with large employers ranging between 29% and 64%).

best modeling.”²³ Moreover, the ACA’s Medicaid costs will vary widely among States:

“State impacts will vary based on current coverage levels across states, generosity of the state’s Medicaid/CHIP eligibility rules and other state-financed coverage programs, existing private insurance regulatory authority, standards, and resources, current state fiscal health, and other factors. Such variation creates difficulties in accurately estimating costs across states. There are substantial differences among states in terms of the percentages of the states’ populations that would meet the definition of “newly eligible” under the mandatory Medicaid expansion as compared to previously eligible individuals. Federal matching rates to share in the cost of Medicaid/CHIP coverage for these individuals under health reform will vary by state, by year, and by eligibility status.”²⁴

Moreover, “Beyond the extra Medicaid costs that states are certain to incur, there are some other state Medicaid cost increases that are probable, but not definite,” such as “payments to so-called Disproportionate Share Hospitals (DSH) and payments to specialist physicians.”²⁵

D. The Law’s Expansive Reach Makes Its Nebulousness More Grave

These uncertainties and variations matter enormously because of the massive scope of the ACA’s expansion of state Medicaid obligations and the ACA’s vast delegation of policymaking to federal officials.²⁶ “Obamacare’s

²³ Congressional Research Service, *Memorandum re: Variation in Analyses of PPACA’s Fiscal Impact on States*, Sept. 8, 2010, at 1 (Pl. App. Ex. 36).

²⁴ *Id.* at 7.

²⁵ Edmund Haislmaier & Brian Blase, *Obamacare: Impact on States*, Heritage Foundation, July 1, 2010 (Backgrounder #2433), available at <http://www.heritage.org/Research/Reports/2010/07/Obamacare-Impact-on-States>.

²⁶ *See Botts v. State*, 604 S.E.2d 512, 515 (Ga. 2004) (“broad language” of statute made its imprecise contours “too vague” to be constitutional, even though those words had a “dictionary definition,” especially since their broad reach had the effect of delegating “basic policy matters” to government officials on “an *ad hoc*” basis).

unfunded mandates are a fiscal time bomb set to explode state balance sheets across the country starting in 2014,” creating a fiscal “crisis,” notes the Heritage Foundation.²⁷ The ACA will force States to “massively expand their already burdensome Medicaid rolls” to include “all non-elderly individuals with family incomes below 138 percent of the federal poverty line.”²⁸ “But that is just the benefit costs. Obamacare does not pay for any of the costs necessary to administer the expansion of the Medicaid rolls, rolls that are expected to increase by approximately 50 percent in states like Nevada, Oregon, and Texas”; indeed, “just the administrative costs of the Obamacare Medicaid expansion will cost almost \$12 billion by 2020.”²⁹ While the ACA’s precise costs are unknown, preliminary estimates suggest staggering increases. In Texas alone, “the Medicaid expansion may add more than 2 million people to the program and cost the state up to \$27 billion in a decade,” while Florida faces “an additional \$5.2 billion in spending between 2013 and 2019 and more than \$1 billion a year beginning in 2017,” and California faces billions in “annual costs”; “The seven-year cost of the Medicaid expansion in Indiana is estimated to be between \$2.59 billion and \$3.11 billion, with 388,000 to 522,000 people joining the state’s Medicaid rolls,” while

²⁷ Heritage Foundation, *Morning Bell: The Obamacare Burden To Your State Budget*, November 12th, 2010 at 9:22am (<http://blog.heritage.org/2010/11/12/morning-bell-the-obamacare-burden-to-your-state-budget/>).

²⁸ *Id.* The 138 percent figure reflects “the 133 percent FPL [federal poverty level] plus extra 5% FPL that is to be disregarded from individuals’ income when determining Medicaid eligibility.” See Congressional Research Service, *Summary of Potential Employer Penalties Under PPACA (P.L. 111-148)*, Apr. 5, 2010, at pg. 2 (available at <http://www.lt.gov.ri.gov/smallbusiness/employerprovisions.pdf>).

²⁹ Heritage Foundation, *The Obamacare Burden To Your State Budget*, *supra* note 27, citing Haislmaier & Blase, *supra* note 25.

“Obamacare will result in nearly one of five Nebraskans being covered by Medicaid.³⁰ (While increasing the States’ costs, the ACA apparently reduces some of their revenues, such as pharmacy rebate revenue.³¹)

The indefinite nature of the States’ long-run financial commitments to Medicaid make the ACA on its face contractually infirm and hence unconstitutional. It also undermines political accountability and aggravates the coerciveness and unduly burdensome nature of the Act.³²

Although the Act indicates that the federal government will initially pay for some Medicaid expansions, the States are advised that they will pay for 10 percent of some unspecified costs in four years, and there is no indication that the States will not pay more in succeeding periods. In the initial, spare introduction of Medicaid in 1965, there was no hint that the States 45 years later would be coerced to spend a substantial proportion of their budgets on Medicaid under the ACA.³³

³⁰ Lanhee Chen, *How Obamacare Burdens Already Strained State Budgets*, Heritage Foundation, Nov. 10, 2010 (Backgrounder #2489) (available at <http://www.heritage.org/Research/Reports/2010/11/How-Obamacare-Burdens-Already-Strained-State-Budgets>), citing estimates by the Florida Agency for Health Care Administration and the California Legislative Analyst’s Office, and a study by the Milliman econometrics experts hired by Nebraska and Indiana).

³¹ See Milliman *Explains Assumptions and Methodology Used in Nebraska Medicaid Budget Exposure Analysis*, Daily Pak Banker, Sept. 19, 2010 (2010 WLNR 18614676).

³² *Virginia v. Riley*, 106 F.3d 559, 571 (4th Cir. 1997) (spending-clause legislation must speak “affirmatively and unambiguously, so that its design is known and the States may marshal their political will in opposition” to expropriations of sovereign rights); *cf. Reno v. ACLU*, 521 U.S. 844, 864 (1997) (“vagueness” relevant to “overbreadth inquiry”).

³³ On average states spend 16.8 percent of their general-fund budgets on Medicaid, with Rhode Island spending 23.5 percent and Minnesota 16.8 percent. See Georgetown Health Policy Institute Center for Children and Families, *Medicaid and State Budgets: Looking at the Facts* (2008), available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/about%20medicaid/nasbo%20final%205-1-08.pdf> (last

States also face great uncertainty as to the Medicaid cost-share ratio for a large new population of single adults without children that the ACA adds to Medicaid.³⁴

E. By Leaving the Federal Government With Unbridled Power to Expand States' Medicaid Obligations, the ACA Violates Principles Forbidding Illusory and Indeterminate Contracts

Even if there were some guarantee of a limitation on State obligations under the ACA's expansions of Medicaid, such a promise would be functionally meaningless. As the Defendants admit, any such promise could be changed at the Defendants' whims, without any limitations or any consent by the States. *See* Defs. Mem. Dis. at 16 (arguing that Congress has "full and complete power" under 42 U.S.C. § 1304 to make any alteration or amendments); *id.* at 15 n.7 ("Here, Congress changed a core element of Medicaid").³⁵ Indeed, backers of the Act have called it a mere "starter home" to be expanded and fleshed out through future legislation and administrative action,³⁶ which will make Medicare a "model of simplicity compared with the current law."³⁷

visited Nov. 10, 2010). Plaintiff States overall spend similar percentages. *Id.* Those percentages will rise under the ACA's expansion of Medicaid.

³⁴ It is not clear whether the ratios will be drawn from the ACA itself, or other legislation, like the enhanced Federal Medical Assistance Percentages under the Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152

³⁵ *See Purgess v. Sharrock*, 33 F.3d 134, 144 (2d Cir. 1994) ("A court can appropriately treat statements in briefs as binding judicial admissions of fact"), *citing Young & Vann Supply Co. v. Gulf F. & A. Ry. Co.*, 5 F.2d 421, 423 (5th Cir.1925).

³⁶ Senator Tom Harkin, *Health Legislation A Solid Foundation to Build Upon*, Wilmington News-Journal, Dec. 30, 2009 (calling passage of the ACA "the opening act in health reform, not the final act. . . I think of the current health reform bill as something of a 'starter home'" that "has plenty of room for additions and improvements")(available in Westlaw news database at 2009 WLNR 26128708); *Harkin Statement on the Social Security and Medicare Board of Trustees Annual Report to Congress*, Aug. 6, 2010 (2010 WLNR 156788171) (again calling ACA "starter home"); *Health Care: Just A Start*,

It cannot be the case that the federal government has unbridled authority to make any amendments to Medicaid, no matter how coercive or arbitrary, or how fundamentally they change the contractual bargain between the federal government and the States. *See* 1 Williston on Contracts § 4:21 (4th ed., updated May 2010) (“a reservation in either party of a future unbridled right to determine the nature of the performance” renders contract “too indefinite for enforcement”).

In contract law, such unbridled power vested in one party makes the contract illusory and non-enforceable. *See* Restatement (Second) Contracts, § 2 *cmt. e* (“Words of promise which by their terms make performance entirely optional with the ‘promisor’ whatever may happen, or whatever course of conduct in other respects he may pursue, do not constitute a promise.”); § 77 *cmt. a* (“Words of promise which by their terms make performance entirely optional with the ‘promisor’ do not constitute a promise.”). For this reason too, as well as for obvious reasons of duress and contractual adhesion, the ACA does not qualify as a contractually enforceable deal with the States, and violates *Pennhurst*’s now-well-

Richmond Times-Dispatch, Jan. 5, 2010 (Harkin called ACA “starter home” with “great foundation” with “room for expansions and additions”) (2010 WLNR 197651); Jacob Hacker, *Health Reform 2.0*, American Prospect, Sept. 1, 2010, at A25 (“Sen. Tom Harkin put the point well when he described the health bill as a “starter home.” What Harkin neglected to mention is that the home isn’t built yet”) (2010 WLNR 17483695).

³⁷ Jacob Hacker, *Health Reform 2.0*, American Prospect, Sept. 1, 2010, at A25 (backer of ACA observes that “Medicare was a model of simplicity compared with the current law”; ACA “eschewed the simple approach to expanding coverage embodied in Medicare”).

accepted contractual conceptualization of Spending Clause conditions.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

Undersigned counsel certifies that on November 19, 2010, a true and correct copy of the foregoing Brief of Governors Tim Pawlenty and Donald L. Carcieri As *Amici Curiae* In Support of Plaintiffs' Motion for Summary Judgment was filed electronically with this Court through the CM/ECF filing system. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's CM/ECF system.

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