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.	)	Case No. 3:10-cv-91-RV/EMT
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,	)	
Defendants.	)	

DEFENDANTS' STATEMENT OF FACTS
AS TO WHICH THERE IS NO GENUINE ISSUE

Defendants, by their undersigned attorneys, hereby list facts as to which there is no genuine issue to be tried, pursuant to Federal Rule of Civil Procedure 56 and Local Rule 56.1(A).

As a preliminary matter, in this facial challenge, slip op. at 1 (Oct. 14, 2010), the Court does not independently review the facts underlying Congress's conclusion that it had the Article I authority to enact the minimum coverage provision. Rather, the Court's task is to determine whether Congress had a "rational basis" to conclude that the class of activities it undertook to regulate, when taken in the aggregate, has a substantial effect on interstate commerce. *Gonzales v. Raich*, 545 U.S. 1, 16-17 (2005). The "legislative facts" underlying Congress's conclusion are accordingly not subject to courtroom proof. *See* Fed. R. Evid. 201 advisory committee's note; *FCC v. Beach Comm'ns*, 508 U.S. 307, 313-15 (1993). It is thus not defendants' burden to prove any such facts at trial or to show at this summary judgment stage that they are not in dispute, genuinely or otherwise.

Moreover, under any set of facts consistent with plaintiffs' allegations, their challenge to the ACA's amendments to Medicaid may be decided as a matter of law. *See, e.g., Steward Machine Co. v. Davis*, 301 U.S. 548 (1937); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981). The Court therefore need not resolve any issues of fact regarding the Medicaid amendments' cost to the states, to the extent they exist, as such issues are not material and do not preclude summary judgment in favor of defendants.

Nevertheless, out of an abundance of caution, and for the convenience of the Court, defendants set out some of the principal facts concerning the challenges presented to the nation that prompted enactment of the Affordable Care Act, and the factual support for those facts that make them, in any event, not genuinely in dispute. Most of these facts are also set forth in the memorandum supporting defendants' motion for summary judgment.

I. Facts Pertaining to Plaintiffs' Challenge to the Minimum Coverage Provision

1. Congress gave detailed consideration to the structure of the reforms of the interstate health insurance market that it enacted in the ACA, as shown by the more than fifty hearings that it held on the subject in the 110th and 111th Congresses alone. *See* H.R. Rep. No. 111-443, pt. II, at 954-68 (2010) (Ex. 1).

2. In 2009, the United States spent more than an estimated 17 percent of its gross domestic product on health care. ACA §§ 1501(a)(2)(B), 10106(a).

3. Notwithstanding these expenditures, 45 million people — an estimated 15 percent of the population — went without health insurance for some portion of 2009. Absent the new statute, that number would have climbed to 54 million by 2019. Cong. Budget Office ("CBO"), *Key Issues in Analyzing Major Health Insurance Proposals* 11 (Dec. 2008) [hereinafter *Key Issues*] (Ex. 2); *see also* CBO, *The Long-Term Budget Outlook* 21-22 (June 2009) (Ex. 3).

4. The pervasive lack of insurance occurred because "[t]he market for health insurance . . . is not a well-functioning market." Council of Economic Advisers ("CEA"), *The Economic Case for Health Care Reform* 16 (June 2009) (submitted into the record for *The Economic Case for Health Reform: Hearing Before the H. Comm. on the Budget*, 111th Cong. 5 (2009)) [hereinafter *The Economic Case*] (Ex. 4).

5. With rare exceptions, individuals cannot make a personal choice to eliminate the current or potential future consumption of health care services. Nor can individuals reliably predict whether they or their families will need health care. They may go without health care for some time, then unexpectedly suffer a debilitating injury or disease and suddenly incur high or even catastrophic health care costs. *See* J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007) (Ex. 5). In this market, everyone is a participant because everyone, in one way or another, is faced with managing the financial risks associated with unpredictable future health care costs. Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions About U.S. Health Insurance*, 27 Health Affairs w533, w534 (2008) (Ex. 6); Jonathan Gruber, *Public Finance and Public Policy* 442-28 (3d ed. 2009) (Ex. 7).

6. When a person does fall ill, he is effectively assured of at least a basic level of emergency care, without regard to his insured status. *See, e.g.*, Fla. Stat. § 395.1041 (2004) ("The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care"); Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (hospitals that participate in Medicare and offer emergency services are required to stabilize, or provide an appropriate transfer for, any patient who arrives, regardless of whether he has insurance or otherwise can pay for that care); CBO, *Key Issues*, at 13. In addition, most hospitals are nonprofit organizations that "have some obligation to provide

care for free or for a minimal charge to members of their community who could not afford it otherwise." *Id.* For-profit hospitals "also provide such charity or reduced-price care." *Id.*

7. Because of the availability of this backstop of free care, many persons have an incentive not to obtain insurance, knowing that they will not bear the full cost of their decision to attempt to pay for their health care needs out-of-pocket. *The Economic Case*, at 17; *see also* Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. of Health Econ. 225, 226 (2005) (Ex. 10).

8. Most individuals make economic decisions whether to attempt to pay for their anticipated health care needs through insurance, or to attempt (often unsuccessfully) to pay out-of-pocket. In making these decisions, individuals weigh the cost of insurance against the cost of their potential out-of-pocket expenses. *See* Mark V. Pauly, *Risks and Benefits in Health Care: The View from Economics*, 26 Health Affairs 653, 657-58 (2007) (Ex. 11). Plaintiff Brown weighs whether purchasing insurance for herself will be a "worthwhile cost of doing business." Am. Compl. ¶ 62.

9. Individuals regularly revisit these economic decisions whether to purchase insurance or attempt to finance their health care needs through another manner. Movement in and out of insured status is "very fluid." Of those who are uninsured at some point in a given year, about 63 percent have coverage at some other point during the same year. CBO, *How Many People Lack Health Insurance and For How Long?* 4, 9 (May 2003) (Ex. 12); *see also* CBO, *Key Issues*, at 11.

10. The vast majority of the population — even of the uninsured population — has participated in the health care market by receiving medical services. *See* June E. O'Neill & Dave M. O'Neill, *Who Are the Uninsured?: An Analysis of America's Uninsured Population, Their Characteristics, and Their Health* 20-22 (2009) (Ex. 8) (94 percent of even long-term uninsured

have received some level of medical care); *see also* National Center for Health Statistics, *Health, United States, 2009*, at 318 (2010) (for 2007, 62.6 percent of uninsured at a given point in time had at least one visit to a doctor or emergency room within the year) (Ex. 9).

11. About 20 percent of the population accounts for 80 percent of health spending, with the sickest one-percent accounting for nearly one-quarter of health expenditures. H.R. Rep. No. 111-443, pt. II, at 990.

12. Insurers have sought to exclude those they deem most likely to incur expenses. *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the S. Comm. on Finance*, 110th Cong. 51-52 (2008) (statement of Mark Hall, Professor of Law and Public Health, Wake Forest Univ.) (Ex. 13). That is, they adopt practices designed — albeit imperfectly — to "cherry-pick healthy people and to weed out those who are not as healthy." H.R. Rep. No. 111-443, pt. II, at 990 (internal quotation omitted).

13. These practices include medical underwriting, or the individualized review of an insurance applicant's health status. This practice is costly, resulting in administrative fees that are responsible for 26 to 30 percent of the cost of premiums in the individual and small group markets. ACA §§ 1501(a)(2)(J), 10106(a). Medical underwriting yields substantially higher risk-adjusted premiums or outright denial of insurance coverage for an estimated one-fifth of applicants for individual coverage, a portion of the population that is most in need of coverage. CBO, *Key Issues*, at 81.

14. Before the ACA, health insurance company practices also included: denial of coverage for those with pre-existing conditions, even minor ones; exclusion of pre-existing conditions from coverage; higher, and often unaffordable, premiums based on the insured's medical history; and rescission of policies after claims are made. *Id.* As a result, "many who need coverage

cannot obtain it, and many more who have some type of insurance may not have adequate coverage to meet their health care needs." *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 53 (2009) (Linda Blumberg, Senior Fellow, Urban Inst.) (Ex. 14). Insurers often revoke coverage even for relatively minor pre-existing conditions. *Consumer Choices and Transparency in the Health Insurance Industry: Hearing Before the S. Comm. on Commerce, Science & Transp.*, 111th Cong. 29-30 (2009) (Karen Pollitz, Research Professor, Georgetown Univ. Health Policy Inst.) (Ex. 15).

15. More than 57 million Americans have some pre-existing medical condition, and thus, absent reform, were at risk for the denial or rescission of insurance coverage. Families USA Foundation, *Health Reform: Help for Americans with Pre-Existing Conditions* 2 (2010) (Ex. 16).

16. Insurers operate in interstate commerce and can gauge their participation in state markets based on the nature of regulation in each state. *See* Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 New Engl. J. Med. e29, at 3 (2010) (Ex. 17).

17. Congress found that the widespread inability of Americans to obtain affordable coverage, or to obtain coverage at all, has significant additional economic effects.

18. 62 percent of all personal bankruptcies are caused in part by medical expenses. ACA §§ 1501(a)(2)(G), 10106(a).

19. The uncertainty that many Americans experience as to whether they can obtain coverage constrains the labor market. The phenomenon of "job lock," in which employees avoid changing employment because they fear losing coverage, is widespread. Employees are 25 percent less likely to change jobs if they are at risk of losing health insurance coverage in doing so. *The Economic Case*, at 36-37; *see also* Gruber, *Public Finance and Public Policy* 431.

20. Insurance industry reform to guarantee coverage would alleviate "job lock" and

increase wages, in the aggregate, by more than $10 billion annually, or 0.2 percent of the gross domestic product. *The Economic Case* 36-37.

21. One result of industry practices that deny, impede, or raise the cost of insurance coverage is that many millions of people are uninsured. In the aggregate, the uninsured shift much of the cost of their care onto other persons. The uninsured continue to receive health care services but pay only a portion of the cost. Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs 2008*, 27 Health Affairs w399, w411 (2008) (Ex. 20); CBO, *Key Issues*, at 114; *see also* CBO, *Nonprofit Hospitals and the Provision of Community Benefits* 1-2 (2006) (Ex. 21)

22. This phenomenon is not limited to the uninsured with the lowest incomes. On average, uninsured persons with incomes of more than 300% of the federal poverty level pay for less than one half of the cost of the medical care that they receive. Herring, 24 J. of Health Econ. at 229-30.

23. The costs of "uncompensated care" for the uninsured fall on other participants in the health care market. In the aggregate, that cost-shifting amounted to $43 billion in 2008, about 5 percent of overall hospital revenues. CBO, *Key Issues*, at 114. Indeed, this figure may underestimate the cost-shifting. One study estimated that the uninsured in 2008 collectively received $86 billion in care during the time they lacked coverage, including $56 billion in services for which they did not pay, either in the form of bad debts or in the form of reduced-cost or free charitable care. Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs 2008*, 27 Health Affairs w399, w411 (2008) (Ex. 20); CBO, *Key Issues*, at 114; *see also* CBO, *Nonprofit Hospitals and the Provision of Community Benefits* 1-2 (2006) (Ex. 21).

24. These costs are in part paid by public funds. For example, through Disproportionate Share Hospital ("DSH") payments, the federal government paid for tens of billions of dollars in uncompensated care for the uninsured in 2008 alone. Congress determined that preventing or reducing cost-shifting would lower these public subsidies. H.R. Rep. No. 111-443, pt. II, at 983; *see also The Economic Case*, at 8.

25. Other costs fall in the first instance on health care providers, who in turn "pass on the cost to private insurers, which pass on the cost to families." ACA § 1501(a)(2)(F), 10106(a). This cost-shifting effectively creates a "hidden tax" reflected in fees charged by health care providers and premiums charged by insurers. CEA, *Economic Report of the President* 187 (Feb. 2010) (Ex. 18); *see also* H.R. Rep. No. 111-443, pt. II, at 985 (2010); S. Rep. No. 111-89, at 2 (2009) (Ex. 19).

26. When premiums increase as a result of cost-shifting by the uninsured, more people who see themselves as healthy make the economic calculation not to buy, or to drop, coverage. For many, this economic calculation leads them to wait to obtain coverage until they grow older, when they anticipate greater health care needs. *See* CBO, *Key Issues*, at 12 (percentage of uninsured older adults in 2007 was roughly half the percentage of uninsured younger adults); *see also* M.E. Martinez & R.A. Cohen, National Center for Health Statistics, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2009*, at 2 (Dec. 2009) (Ex. 22); U.S. Census Bureau, *Census Population Survey, Annual Social and Economic Supplement* (2009) (Table H101, data on coverage status by age) (Ex. 23).

27. This self-selection further narrows the risk pool, which, in turn, further increases the price of coverage for the insured. The result is a self-reinforcing "premium spiral." *Health Reform in the 21st Century: Insurance Market Reforms* 118-19 (2009) (American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at 985.

28. This premium spiral particularly hurts small employers, due to their relative lack of bargaining power. *See* H.R. Rep. No. 111-443, pt. II, at 986-88; *The Economic Case*, at 37-38; *see also 47 Million and Counting* 36 (Raymond Arth, Nat'l Small Business Ass'n) (noting need for insurance reform and minimum coverage provision to stem rise of small business premiums).

29. To address the economic effects of these market failures, as well as to protect consumers, the ACA comprehensively "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." ACA §§ 1501(a)(2)(A), 10106(a).

30. The minimum coverage provision "is an essential part of this larger regulation of economic activity," and its absence "would undercut Federal regulation of the health insurance market." *Id.* §§1501(a)(2)(H), 10106(a).

31. By "significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums." *Id.* §§ 1501(a)(2)(F), 10106(a).

32. Without the minimum coverage provision, the reforms in the Act, such as the ban on denying coverage or charging more based on pre-existing conditions, would amplify existing incentives for individuals to "wait to purchase health insurance until they needed care," thereby further shifting costs onto third parties. *Id.* §§ 1501(a)(2)(I), 10106(a). The minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

33. The new "guaranteed issue" and "community rating" requirements under section 1201 of the Act ensure that all Americans can obtain coverage subject to no coverage limits and

despite the pre-existing conditions they may have at that time. ACA § 1201. Because these new insurance regulations would allow individuals to "wait to purchase health insurance until they needed care," *id.* §§ 1501(a)(2)(I), 10106(a), they would increase the incentives for individuals to "make an economic and financial decision to forego health insurance coverage" until their health care needs become substantial, *id.* §§ 1501(a)(2)(A), 10106(a).

34. Individuals who would make that decision would take advantage of the ACA's reforms by joining a coverage pool maintained in the interim through premiums paid by other market participants. Without a minimum coverage provision, this market timing would increase the costs of uncompensated care and the premiums for the insured pool, creating pressures that would "inexorably drive [the health insurance] market into extinction." *Health Reform in the 21st Century: Insurance Market Reforms* 13 (Uwe Reinhardt, Ph.D., Professor of Political Economy, Economics, and Public Affairs, Princeton University).

35. This danger is not merely theoretical, but is borne out in the experience of states that have attempted "guaranteed issue" and "community rating" reforms without an accompanying minimum coverage provision. After New Jersey enacted a similar reform, its individual health insurance market experienced higher premiums and decreased coverage. *See* Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey,* 23 Health Affairs 167, 168 (2004) (Ex. 25) (describing potential for "adverse-selection death spiral" in a market with guaranteed issue); *see also Health Reform in the 21st Century: Insurance Market Reforms* 101-02 (Dr. Reinhardt).

36. Likewise, after New York enacted a similar reform, "the market for individual health insurance in New York has nearly disappeared." Stephen T. Parente & Tarren Bragdon, *Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured,* Medical Progress

Report, No. 10 at I (Manhattan Institute, Sept. 2009) (Ex. 26).

37. In contrast, Massachusetts enacted "guaranteed issue" and "community rating" reforms, coupled with a minimum coverage provision. Since 2006, the average individual premium in Massachusetts has decreased by 40 percent, compared to a 14 percent increase in the national average. Jonathan Gruber, Mass. Inst. of Tech., *The Senate Bill Lowers Non-Group Premiums: Updated for New CBO Estimates*, at 1 (Nov. 27, 2009) (Ex. 27); *see also* Letter from Mitt H. Romney, Governor of Massachusetts, to State Legislature at 1-2 (Apr. 12, 2006) (Ex. 28) (signing statement for Massachusetts bill, noting need for insurance coverage requirement to prevent cost-shifting by the uninsured).

38. In short, "fundamental insurance-market reform is impossible" if the guaranteed-issue and community-rating reforms are not coupled with a minimum coverage provision. Jonathan Gruber, *Getting the Facts Straight on Health Care Reform*, 316 New Eng. J. of Med. 2497, 2498 (2009) (Ex. 29). This is because "[a] health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." *47 Million and Counting*, at 52 (Prof. Hall). Accordingly, Congress found that the minimum coverage provision is "essential" to its broader effort to regulate health insurance industry underwriting practices that have prevented many from obtaining health insurance. ACA §§ 1501(a)(2)(I), (J), 10106(a).

39. The minimum coverage provision also addresses the unnecessary costs created by the insurance industry's practice of medical underwriting. "By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums," and is therefore "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs."

ACA §§ 1501(a)(2)(J), 10106(a).

II. Facts Pertaining to Plaintiffs' Challenge to the ACA's Amendments to Medicaid

40. The CBO estimates that, under the ACA, federal Medicaid outlays will increase by $434 billion, and state outlays by $20 billion, through 2019. Letter from Douglas W. Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives tbl.4 (Mar. 20, 2010) (Ex. 32) [hereinafter CBO Letter to Speaker Pelosi].

41. The CBO estimates that, under the ACA, the federal government will shoulder more than 95 percent of all new Medicaid spending through 2019. *See* CBO Letter to Speaker Pelosi tbl.4.

42. The CBO estimates that, under the ACA, any new federal spending, including on Medicaid, will be offset by other revenue-raising and cost-saving provisions. CBO Letter to Speaker Pelosi at 2.

43. The CBO estimates that the Medicaid expansion will increase Medicaid enrollment by about 16 million by 2019. CBO Letter to Speaker Pelosi tbl.4.

44. Nationally, the Medicaid expansion will reduce by 44.5 percent the number of uninsured adults below 133 percent of the federal poverty level. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 10 tbl.1 (May 2010) (Ex. 34).

45. In Florida, the federal government is expected to pay for 94.2 percent of the Medicaid expansion through 2019, while the number of uninsured adults below 133 percent of the federal poverty level is expected to decline by 44.4 percent. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 10 tbl.1 (May 2010).

46. In South Carolina, the federal government is expected to pay for 95.9 percent of the Medicaid expansion through 2019, while the number of uninsured adults below 133 percent of the

federal poverty level is expected to decrease by 56.4 percent. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 10 tbl.1 (May 2010).

47. Compared to baseline projections in the absence of reform, by the end of 2019, average state Medicaid spending under the ACA is expected to increase 1.4 percent. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 10 tbl.1 (May 2010).

48. Many states currently subsidize health care *outside* of Medicaid, in programs funded entirely with state or local dollars, for individuals that will be eligible for Medicaid under the ACA. Council of Economic Advisers ("CEA"), *The Impact of Health Insurance Reform on State and Local Governments*, at 4-5 (Sept. 15, 2009) (Ex. 33) [hereinafter "*The Impact on States*"].

49. Pennsylvania subsidizes coverage for adults under 200 percent of FPL through its adultBasic program, at a cost of $172 million in 2008. CEA, *The Impact on States*, at 85.

50. Indiana subsidizes coverage for adults under 200 percent of FPL through its Healthy Indiana Plan, at a cost of $154.8 million in 2009, and separately funded millions in emergency care for the indigent in fiscal year 2010-11. CEA, *The Impact on States*, at 34-35.

51. Many states, like Pennsylvania and Indiana, currently subsidize health care for some individuals falling between 133 percent and 400 percent of FPL using only state or local funds. CEA, *The Impact on States*, at 34-35, 85.

52. Many states, including Idaho, Indiana, and Nebraska, currently fund high-risk insurance pools to subsidize coverage for individuals who have been denied private coverage due to pre-existing conditions. CEA, *The Impact on States*, at 29, 35, 67.

54. Miami-Dade County, Florida, currently funds uncompensated care at public facilities through a 0.5 percent sales tax, which raised $187 million in fiscal year 2007. CEA, *The Impact on*

States, at 24.

55. It is estimated that, under the ACA, state and local governments will recoup up to $1.6 billion per year of the "hidden tax" that cost-shifting imposes on health insurance premiums. for their employees. CEA, *The Impact on States*, at 6.

56. Taken together, the savings that will accrue to states from (1) the downsizing or elimination of duplicative state programs and (2) the reduction in the "hidden tax" on premiums now borne by state governments, are estimated at $11 billion *per year* after 2013. CEA, *The Impact on States*, at 6-7. Florida alone is projected to save $377 million per year. *Id.* at 6, 26.

57. It is estimated that state and local governments would save approximately $70-80 billion over the 2014-2019 period by shifting currently state-funded coverage into federally matched Medicaid. John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [ACA] on the States?*, at 2 (June 2010) (Ex. 35).

58. It is estimated that states' savings from no longer having to finance as much of the cost of providing uncompensated care to the uninsured may fully offset the increase in Medicaid costs resulting from the Medicaid expansion. J. Angeles, Center on Budget and Policy Priorities, *Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law*, at 10 (Oct. 21, 2010) (Ex. 36).

59. Increases in federal Medicaid funding will generate economic activity at the state level, including jobs and state tax revenues. Kaiser Family Foundation, *Health Reform Issues: Key Issues About State Financing and Medicaid*, at 3 (May 2010) (Ex. 37).

60. Absent reform, state Medicaid/CHIP spending is estimated to increase 60.7 percent by 2019 even under the best-case scenario. Bowen Garrett et al., Urban Institute, *The Cost of Failure to Enact Health Reform: Implications for States*, at 13 tbl.2B (Sept. 30, 2009) (Ex. 38).

61. There is a "great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership, and priorities." Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 1 (May 2010).

62. In fiscal year 2008, federal Medicaid grants ranged from $246 million (Wyoming) to $23.8 billion (New York). Kaiser Family Foundation, *Federal & State Share of Medicaid Spending, FY2008* (Ex. 39).

63. In fiscal year 2008, federal medical assistance percentages ("FMAPs") ranged from 50 percent (several states, including Colorado) to 76 percent (Mississippi). 71 Fed. Reg. 69209, 69210 (Nov. 30, 2006).

64. In fiscal year 2008, state spending on Medicaid, as a proportion of total state revenues, ranged from 8.4 percent (Alaska) to 34.5 percent (Missouri). Nat'l Ass'n of State Budget Officers, *Fiscal Year 2008 State Expenditure Report*, at 10 tbl.5 (Fall 2009) (Ex. 40) [hereinafter NASBO Report].

65. In fiscal year 2008, the proportion of total state revenues formed by federal Medicaid grants ranged from 4.4 percent (Alaska) to 21.5 percent (Missouri). *See* NASBO Report at 10 tbl.5; 71 Fed. Reg. at 69210.

65. In fiscal year 2008, Mississippi spent 11 percent of its budget on Medicaid. NASBO Report at 10 tbl.5.

67. In fiscal year 2008, Pennsylvania spent more than 30 percent of its budget on Medicaid. NASBO Report at 10 tbl.5.

68. Many states, including Florida, provide subsidized care outside of Medicaid, funded entirely with state or local dollars. CEA, *The Impact on States*, at 23-26.

69. The vast majority of states collect personal income, corporate income, and sales

taxes. Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source* (Ex. 42).

70. Six plaintiff states (Alaska, Florida, Nevada, South Dakota, Texas, and Washington) impose no personal income tax. Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source*.

71. Three plaintiff states (Nevada, Texas, and Washington) impose no corporate income tax. Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source*.

72. One plaintiff state (Alaska) imposes no sales tax. Fed'n of Tax Adm'rs, *2009 State Tax Collection by Source*.

73. Of the 10 states in the nation with the lowest per capita tax burden, 7 are plaintiffs here (Alabama, Arizona, Colorado, Florida, Georgia, South Carolina, South Dakota, and Texas). Fed'n of Tax Admins., *2009 State Tax Revenue* (Ex. 43).

74. Between 1966 and 2000, Medicaid enrollment expanded from 4 million to 33 million. John Klemm, Ph.D., *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 106 (Fall 2000) (Ex. 31).

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CERTIFICATE OF SERVICE

I hereby certify that on November 4, 2010, the foregoing document was filed with the Clerk of Court via the CM/ECF system, causing it to be served on Plaintiffs' counsel of record.

/s/ *Eric B. Beckenhauer*
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