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.	)	

MEMORANDUM IN SUPPORT OF
DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The Patient Protection and Affordable Care Act ("ACA" or "the Act") is an important advance that builds on prior reforms of the interstate health insurance market over the last 35 years. Focusing on insurance industry practices that prevented millions of Americans from obtaining affordable insurance, the Act bars insurers from denying coverage to those with pre-existing conditions or from charging discriminatory premiums on the basis of medical history. Congress recognized that these reforms of insurance industry practices were required to protect consumers and to correct a failure in the interstate health insurance market. Such reforms are within Congress's power under the Commerce Clause. Congress also rationally found that the minimum coverage provision is necessary to ensure that these guaranteed-issue, pre-existing condition, and community-rating reforms succeed. In dismissing plaintiffs' due process claim, this Court agreed. Slip op. at 60 (Oct. 14, 2010) [Doc. No. 79]. That determination also establishes that Congress has the authority to take this measure to ensure the success of its larger reforms of the interstate market. *Gonzales v. Raich*, 545 U.S. 1, 18 (2005). Indeed, that is precisely what the first Court to reach a final merits judgment addressing the constitutionality of this provision has concluded. *Thomas More Law Ctr. v. Obama*, 2010 WL 3952805, at *6-11 (E.D. Mich. Oct. 7, 2010).

Even if considered in isolation, the minimum coverage provision would easily fall within the commerce power, for it regulates conduct that has substantial effects on interstate commerce. Although plaintiffs attempt to portray the uninsured as sitting passively outside the health *insurance* market, virtually no one is outside the health *care* market. Moreover, the vast majority of individuals whose conduct is regulated by the minimum coverage provision either currently have insurance; have had it within the past year; or affirmatively seek insurance but are unable to obtain it without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion

that the Act will provide. Plaintiffs do not and cannot dispute, for example, that those who currently have insurance or will soon obtain it are "active" participants in both the health insurance and health care markets and thus that their conduct is subject to regulation under the Commerce Clause. Even as to the uninsured, plaintiffs concede that Congress may require that they, too, obtain insurance at the point of procuring health care services, Tr. 62-63 (Sept. 14, 2010), and quibble only that "formalism" prevents the government from requiring insurance in advance of its use, *id.*, thus claiming that Congress must turn a blind eye to the fact that in the aggregate, virtually everyone will at some point obtain medical services. This both misses the point of insurance — which is precisely to pay to cover services in advance of receiving them — and challenges the constitutionality of a broad federal statute based on its application to a subset of those who are regulated.

Plaintiffs also do not dispute that the uninsured receive tens of billions of dollars in health care services and in many cases cannot pay. In the aggregate, the uninsured shift $43 billion in the cost of their care annually to other market participants, including providers, insurers, and the insured population. Moreover, the absence of health insurance renders Americans more hesitant to change jobs, contributes substantially to the number of personal bankruptcies, and causes premium rates to spriral. Uninsured Americans make, revisit, and revise *economic* decisions about how to finance their health care needs. Plaintiff Mary Brown, for example, weighs whether buying health insurance is a "worthwhile cost of doing business." Am. Compl. ¶ 62. Congress may regulate these economic actions when they substantially affect interstate commerce, *Raich*, 545 U.S. at 17, as they do here, *Thomas More*, 2010 WL 3952805, at *10.

Plaintiffs' challenge to the Act's amendments to Medicaid is likewise meritless. As this Court has recognized, no court has ever found a federal spending program to be impermissibly coercive. Slip op. at 55. That is no surprise. After 70 years on the books as a hypothetical caveat

to the broad congressional spending power, the "coercion" theory still lacks any judicially administrable standards and essentially raises political questions that fall outside the province of the judiciary, as several courts have held. Even if this claim is justiciable, the courts have uniformly sustained conditional spending programs, no matter their size or importance, including Medicaid itself, against such challenges. In any event, the very basis of plaintiffs' claim — that the Medicaid amendments will "run [their] budgets off a cliff," *id.* at 50 — is inaccurate. Increases in state Medicaid spending will be more than offset by new savings created by other provision of the Act. In the end, plaintiffs cannot escape the "simple and unassailable fact" that "state participation in Medicaid under the [ACA] is, as it has always been, entirely voluntary." *Id.* at 51. States are "ultimately free to reject both the conditions and the funding, no matter how hard that choice may be," *Kansas v. United States*, 214 F.3d 1196, 1203 (10th Cir. 2000), and that freedom is not rendered illusory by the size of the grant or its importance to state finances. Under the Spending Clause, Congress may put such choices to the states, and the states are "fully competent to make their own choice." *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000).

As this Court has recognized, plaintiffs have brought a "facial challenge" to the ACA. Slip op. at 1. In this facial challenge, plaintiffs bear the heavy burden of showing that there are *no* possible circumstances in which the challenged provisions could be constitutionally applied. They cannot meet this burden. They cannot show that the minimum coverage provision would be unconstitutional in *any* of its applications, and they cannot show, even under their anachronistic Commerce Clause theories, that the provision is unconstitutional in *all* of them. Nor can they show that the amendments to Medicaid have transformed this voluntary program into an unduly coercive one in any state, let alone with respect to every state.

STATEMENT OF THE CASE

Congress gave detailed consideration to the structure of the reforms of the interstate health insurance market 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). The following facts are among those Congress took into account in concluding that it had authority under Article I of the Constitution to enact the ACA and, in particular, the minimum coverage provision.[1]

A. The Widespread Lack of Insurance Coverage in the Interstate Market

In 2009, the United States spent more than 17 percent of its gross domestic product on health care. ACA §§ 1501(a)(2)(B), 10106(a).[2] 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). The pervasive lack of insurance occurred because "[t]he market for health insurance . . . is not a well-functioning market." Coun. of Econ. Advisers ("CEA"), *The Economic Case for Health Care Reform* 16 (June 2009) (submitted into the record for *The Economic Case for Health Reform:*

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[1] This Court does not independently review the facts underlying Congress's conclusion that it had the Article I authority to enact a statute. The Court's task instead is to determine "whether a 'rational basis' exists" for Congress to so conclude. *Gonzales v. Raich*, 545 U.S. 1, 22 (2005) (quoting *United States v. Lopez*, 514 U.S. 549, 557 (1995)). The "legislative facts" underlying the conclusion are accordingly not subject to courtroom proof. *See* Fed. R. Evid. 201 advisory committee's note; *FCC v. Beach Commc'ns*, 508 U.S. 307, 313-15 (1993).

[2] Although Congress is not required to set forth particularized findings of an activity's effect on interstate commerce, when, as here, it does so, courts "will consider congressional findings in [their] analysis." *Raich*, 545 U.S. at 21.

Hearing Before the H. Comm. on the Budget, 111th Cong. 5 (2009)) [hereinafter *The Economic Case*] (Ex. 4). Several features unique to the health insurance market caused that market to fail and prevented many from obtaining needed insurance.

First, virtually no individuals can make a personal choice to eliminate all current or potential future consumption of health care services. An individual may go without health care for years, 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). This combination of universal need and unavoidable uncertainty gave rise to the private health insurance industry, federal programs such as Medicare and Medicaid, and federal regulation under statutes such as ERISA, COBRA, EMTALA, and HIPAA. 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. Baicker & Chandra, *Myths and Misconceptions About U.S. Health Insurance*, 27 Health Affairs w533, w534 (2008) (Ex. 6); Jonathan Gruber, *Public Finance and Public Policy* 422-28 (3d ed. 2009) (Ex. 7). Far from being inactive bystanders, the vast majority of the population — even of the uninsured population — has participated in the health care market by receiving medical services. *See* O'Neill & 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); 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).

When a person does need emergency care, he is effectively assured of at least a basic level of care without regard to his insured status or ability to pay. *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; CBO, *Key Issues*, at 13.[3] Because 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. Health Econ. 225, 226 (2005) (Ex. 10).

Most individuals make economic decisions whether 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 Mary Brown, for example, will weigh whether insuring herself will be a "worthwhile cost of doing business." Am. Compl. ¶ 62. Individuals regularly revisit these economic decisions whether to purchase insurance or attempt to finance their health care needs through another manner. Of those who are uninsured at some point in a given year, about 63 percent have coverage at some other point during that year. CBO, *How Many People Lack Health Insurance and For How Long?* 4, 9 (May 2003) (Ex. 12); *see also Key Issues*, at 11.

[3] Nonprofit hospitals "have some obligation to provide care for free or for a minimal charge to members of their community who could not afford it otherwise" and for-profit hospitals "also provide such charity or reduced-price care." *Id.*

B. Insurance Industry Incentives to Deny Coverage Under Prior Law

Insurers have sought to exclude from coverage 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, Prof. of Law & 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). These practices include medical underwriting, or the individualized review of an insurance applicant's health status. This practice is costly, and contributes to the administrative expenses that comprise 26 to 30 percent 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.

Based on this medical underwriting, prior to the ACA, health insurers also: denied coverage for those with pre-existing conditions, even minor ones; excluded pre-existing conditions from coverage; charged higher, and often unaffordable, premiums based on the insured's medical history; and rescinded policies after claims were made. *Id.* These practices were often harsh and unfair for consumers, in that "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 & Means*, 111th Cong. 53 (2009) (Linda Blumberg, Sr. Fellow, Urban Inst.) (Ex. 14). Insurers often revoked cover-age even for relatively minor pre-existing conditions. *Consumer Choices & Transparency in the Health Insurance Industry: Hearing Before the S. Comm. on Commerce, Science & Transp.*,

111th Cong. 29-30 (2009) (Karen Pollitz, Research Prof., Georgetown Univ. Health Policy Inst.) (Ex. 15).

More than 57 million Americans have some pre-existing medical condition, and thus, absent reform, were at risk for such denial or rescission of insurance coverage. Families USA Foundation, *Health Reform: Help for Americans with Pre-Existing Conditions* 2 (2010) (Ex. 16). Given that insurers operate in interstate commerce and can gauge their participation in state markets based on the regulation in each state, *see* Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 New Eng. J. Med. e29, at 3 (2010) (Ex. 17), Congress concluded that there was a need for regulatory protection at a national level.

C. The Substantial Economic Effects of the Lack of Insurance Coverage

Congress found that the failure to maintain health insurance coverage has significant additional economic effects. For example, 62 percent of all personal bankruptcies are caused in part by medical expenses. ACA §§ 1501(a)(2)(G), 10106(a). The uncertainty that many experience as to whether they can obtain coverage also constrains the interstate 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. 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*, at 36-37.

In the aggregate, the uninsured shift much of the cost of their care onto other persons, because they receive health care services but pay only a portion of the cost. Herring, 24 J. Health Econ. at 229-30. This phenomenon is not limited to the uninsured with the lowest incomes. On

average, uninsured persons with incomes of more than 300 percent of the federal poverty level pay for less than half the cost of the medical care they receive. *Id*. In the aggregate, cost-shifting by the uninsured 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.[4]

In part, public funds subsidize these costs, and 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. Other costs fall in the first instance on health care providers, who may 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).

D. "Premium Spiral"

As insurance becomes more expensive in the absence of any requirement to have health insurance, 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 roughly half the percentage of uninsured younger

[4] Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, & Incremental Costs 2008*, 27 Health Affairs w399, w411 (2008) (Ex. 20); CBO, *Key Issues*, at 114; *see* CBO, *Nonprofit Hospitals & the Provision of Community Benefits* 1-2 (2006) (Ex. 21).

adults); *see also* M.E. Martinez & R.A. Cohen, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2009*, National Center for Health Statistics, 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). This self-selection narrows the risk pool, which, in turn, 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* at 118-19 (2009) (statement of American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at 985.

E. The Reforms of the Affordable Care Act

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).[5] The reform has five main components.

First, to address inflated premiums in the individual and small-business insurance market, section 1311 of the Act establishes health insurance exchanges "as an organized and transparent marketplace for the purchase of health insurance where individuals and employees (phased-in over time) can shop and compare health insurance options." H.R. Rep. No. 111-443, pt. II, at 976 (internal quotation omitted).

Second, the Act builds on the existing system of employer-based health insurance, in which most individuals receive coverage as part of employee compensation. *See* CBO, *Key Issues*, at 4-5.

[5] The ACA, Pub. L. No. 111-148, 124 Stat. 119 (2010), was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA"). Unless otherwise stated, all citations in this memorandum to the ACA are to that Act as amended by HCERA.

It creates tax incentives for small businesses to purchase health insurance for employees and prescribes potential penalties for certain large businesses that do not offer their employees adequate coverage if a full-time employee receives a tax credit in an Exchange. ACA §§ 1421, 1513.

Third, the Act helps many of the uninsured afford coverage. As Congress understood, nearly two-thirds of the uninsured are in families with income less than 200 percent of the federal poverty level, H.R. Rep. No. 111-443, pt. II, at 978; *see also* CBO, *Key Issues*, at 27, while 4 percent of those with income greater than 400 percent of the poverty level are uninsured. CBO, *Key Issues*, at 11. The Act reduces this gap by providing premium tax credits and reduced cost-sharing for individuals and families with income between 100 and 400 percent of the federal poverty line, ACA §§ 1401-02, and expands eligibility for Medicaid to individuals with income below 133 percent of the federal poverty level beginning in 2014, *id.* § 2001.

Fourth, the Act removes barriers to insurance coverage. The Act bars insurers from refusing to cover individuals with pre-existing medical conditions. ACA § 1201. The Act also prevents insurers from rescinding coverage for any reason other than fraud or intentional misrepresentation of material fact, and from declining to renew coverage based on health status. *Id.* §§ 1001, 1201. Further, with limited exceptions, the Act prohibits insurers from charging higher premiums on the basis of the insured's prior medical history. *Id.* § 1201. And it prohibits dollar caps on the coverage available to a policyholder in a given year or over a lifetime. *Id.* §§ 1001, 10101(a).

Fifth, the Act requires that all Americans, with specified exceptions, maintain a minimum level of health insurance coverage, or pay a penalty. ACA §§ 1501, 10106; HCERA § 1002. Congress found that this minimum coverage provision "is an essential part of this larger regulation of economic activity," and that its absence "would undercut Federal regulation of the health insurance market." ACA §§1501(a)(2)(H), 10106(a).

ARGUMENT

Plaintiffs "raise[ ] a facial challenge" to the ACA. Slip op. at 1. Plaintiffs accordingly bear the burden of showing that "no set of circumstances exist under which the Act would be valid," *United States v. Salerno*, 481 U.S. 739, 745 (1987), that is, "that the law is unconstitutional in *all* of its applications." *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (emphasis added); *accord, e.g.*, *United States v. Paige*, 604 F.3d 1268, 1273 (11th Cir. 2010). Plaintiffs cannot carry that heavy burden of showing that there is no set of circumstances under which the individual responsibility provision or the Medicaid amendments is valid.

I. CONGRESS VALIDLY EXERCISED ITS POWER UNDER THE COMMERCE AND NECESSARY AND PROPER CLAUSES TO ENACT THE MINIMUM COVERAGE PROVISION

A. Congress Validly Exercised Its Commerce Power to Enact the Minimum Coverage Provision, Because the Provision Is Integral to the ACA's Larger Regulatory Scheme

1. Congress Has Broad Authority to Regulate Interstate Commerce

The Constitution grants Congress power to "regulate Commerce . . . among the several States," U.S. Const. art. I, § 8, cl. 3, and to "make all Laws which shall be necessary and proper" to the execution of that power, *id*. cl. 18. This grant of authority is broad, allowing Congress, among other things, to "regulate activities that substantially affect interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 16-17 (2005). In assessing whether an activity substantially affects interstate commerce, Congress may consider the aggregate effect of a particular form of conduct in deciding whether to exercise its Commerce Clause authority. The question is not whether any one person's conduct, considered in isolation, affects interstate commerce, but whether there is a rational basis for concluding that the class of activities, "taken in the aggregate," substantially affects interstate commerce. *Raich*, 545 U.S. at 22; *see also Wickard v. Filburn*, 317 U.S. 111, 127-28 (1942).

"'Where the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class.'" *Raich*, 545 U.S. at 23 (quoting *Perez v. United States*, 402 U.S. 146, 154 (1971) (internal quotation omitted)). For example, the "comprehensive federal registration system" created by the Sex Offender Registration Act ("SORNA"), "may implicate a sex offender who does not cross state lines," but has been sustained under the Commerce Clause since "the potential for recidivism and flight across state lines of *all* sex offenders is sufficiently real and substantial to be taken as a serious and extensive part of the larger interstate problem, justifying the comprehensive regulation . . . [r]equiring *all* sex offenders to register." *United States v. Gould*, 568 F.3d 459, 474-75 (4th Cir. 2009) (emphasis original); *see also United States v. Ambert*, 561 F.3d 1202, 1210 (11th Cir. 2009) (upholding SORNA under Commerce Clause); *United States v. Olin Corp.*, 107 F.3d 1506, 1510-11 (11th Cir. 1997) (sustaining CERCLA despite landowner's argument that there was "no evidence that *its* on-site disposal has caused off-site damage, much less harmed interstate commerce").

The commerce power provides authority to Congress in a second way relevant to this case. In exercising its Commerce Clause power, Congress may also reach even wholly intrastate, non-commercial matters when it concludes that the failure to do so would undercut a larger program regulating interstate commerce. *Raich*, 545 U.S. at 18; *United States v. Maxwell*, 446 F.3d 1210, 1215 (11th Cir. 2006). Thus, when "a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence." *Raich*, 545 U.S. at 17 (internal quotation omitted); *see also id.* at 37 (Scalia, J., concurring in the judgment) (Congress's authority to make its regulation of commerce effective is "distinct" from its authority to regulate matters that substantially affect interstate commerce). For the provisions of "'[a] complex regulatory program'" to fall within Congress's commerce power,

"'[i]t is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole'" satisfies this test. *Alabama-Tombigbee Rivers Coal. v. Kempthorne*, 477 F.3d 1250, 1276 (11th Cir. 2007) (quoting *Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981)).

"[T]he principle that Congress may regulate some intrastate activity as an essential part of a larger permissible regulation is" not "limited to the facts of *Raich* and *Wickard*," but has a "much richer history" and helps "ensur[e] sufficient deference to Congress' legislative authority." *Id.* at 1276. Thus, in assessing congressional judgments regarding the impact on interstate commerce of and the necessity of individual provisions to the overall scheme of reform, the Court's task "is a modest one." *Raich*, 545 U.S. at 22. The Court need not itself measure the impact on interstate commerce of the activities Congress sought to regulate, nor need the Court calculate how integral a particular provision is to a larger regulatory program. The Court's task instead is limited to determining "whether a 'rational basis' exists" for Congress's conclusions. *Id.* (quoting *United States v. Lopez*, 514 U.S. 549, 557 (1995)).

Raich and *Wickard* illustrate the breadth of the commerce power and the deference accorded Congress's judgments. Persons who finance their health care consumption without purchasing insurance are engaged in economic activity to at least as great an extent as the plaintiffs in *Raich*, who consumed only home-grown marijuana. It was undisputed in *Raich* that Congress could regulate possession of marijuana even when no interstate transaction had taken place. The plaintiffs urged, however, that persons who grew marijuana for personal use had declined to become part of the market and had not engaged in economic activity. The Supreme Court rejected this challenge, finding that "Congress had a rational basis for concluding that leaving home-consumed marijuana outside federal control would . . . affect price and market conditions." *Id.* at 19.

Raich reflected principles established in *Wickard v. Filburn*, 317 U.S. 111 (1942), where the Court upheld Congress's authority to regulate home-grown wheat to be consumed on Filburn's own farm. It was irrelevant, the Court explained, that Filburn had chosen to consume home-grown wheat rather than to purchase wheat on the market. Filburn's consumption of the wheat he produced, when aggregated with the home consumption of other farmers, would have disrupted the federal price scheme and thus was subject to federal regulation. *See Raich*, 545 U.S. at 19 ("[i]n *Wickard*, we had no difficulty concluding that Congress had a rational basis for believing that, when viewed in the aggregate, leaving home-consumed wheat outside the regulatory scheme would have a substantial influence on price and market conditions").

Raich and *Wickard* demonstrate the deference that the Court gives to Congress's judgment regarding how to structure systems of economic regulation. Indeed, in the nearly 70 years since the Court confirmed the breadth of the commerce power in *United States v. Darby*, 312 U.S. 100 (1941), the Court has invalidated statutes as beyond the reach of that power on only two occasions. *United States v. Lopez*, 514 U.S. 549 (1995); *United States v. Morrison*, 529 U.S. 598 (2000). In sharp contrast to the system of health insurance regulation at issue in the ACA, neither of those two statutes involved *economic* regulation, much less direct regulation of an industry that constitutes more than one-sixth of the GDP. Nor did either of those two statutes have any connection to a broader scheme of economic regulation. In *Morrison*, the Court invalidated a tort cause of action created in the Violence Against Women Act, finding that any link between gender-motivated violence and economic activity could be found only through a chain of speculative assumptions. Similarly, in *Lopez*, the Court struck down a ban on possession of a handgun in a school zone because the ban was not part of an overall scheme of firearms regulation, and it related to economic activity only insofar as the presence of guns near schools might impair learning, which in turn might

undermine economic productivity. The Court reasoned that Congress may not "pile inference upon inference" to find a link to interstate commerce. *Lopez*, 514 U.S. at 567.

In contrast, "[n]o piling is needed here to show that Congress was within its prerogative" to regulate interstate commerce. *Sabri v. United States*, 541 U.S. 600, 608 (2004). It is difficult to imagine a more directly economic focus of legislation than the regulation of how health care services are financed. The minimum coverage provision thus regulates matters with direct and substantial effects on interstate commerce. *Thomas More*, 2010 WL 3952805, at *9. And the minimum coverage provision forms an integral part of the ACA's larger reforms of health insurance industry practices. Those market reforms fall within the commerce power, and Congress had authority to enact a measure it deemed necessary to make those reforms effective. *Id*. at *10.

Indeed, even under plaintiffs' own theories, the law is not "unconstitutional in all of its applications," *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008), and is therefore constitutional. Many of the formerly uninsured will *want* to have insurance now that the ACA will guarantee issuance and help lower the cost. Many other uninsureds who enter and exit the insurance market over time are not "inactive" in any reasonable sense of the word; rather, they are making economic decisions about when and how ultimately to pay for health care, all the while shifting costs and imposing economic effects on others in the health care market. And plaintiffs concede that, even those non-exempted individuals who neglect to buy insurance ahead of time can be required to buy it when, in plaintiffs' view, they finally do become active and need to pay for health care. Tr. 62-63 (Sept. 14, 2010). That "insurance" bought in the hospital emergency room is not really "insurance" at all illustrates the ultimately empty formalism of plaintiffs' insistence that Congress cannot fully exercise its commerce power in regulating this market.

2. Congress Has Constitutional Power to Regulate the Interstate Market in Health Insurance

Regulation of a vast interstate market for health care constituting more than 17 percent of the gross domestic product is well within congressional authority under the Commerce Clause. ACA §§ 1501(a)(2)(B), 10106(a). It has long been established that Congress may regulate interstate insurance markets, including the interstate market for health insurance. In *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), the Court recognized that the business of insurance, by its nature, involves payments from and to insurers among the various states: "The result is a continuous and indivisible stream of intercourse among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts." *Id*. at 541. The Court accordingly held that the business of insurance is interstate commerce, which Congress has the power to regulate:

> Our basic responsibility in interpreting the Commerce Clause is to make certain that the power to govern intercourse among the states remains where the Constitution placed it. That power, as held by this Court from the beginning, is vested in the Congress, available to be exercised for the national welfare as Congress shall deem necessary. No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.

Id. at 552-53.

For more than 35 years, Congress has repeatedly exercised its constitutional authority to regulate the business of health insurance, for example, by providing directly for government-funded health insurance through the Medicare Act, and by enacting numerous statutes regulating the content of policies offered by private insurers.[6]

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[6] *See* Employee Retirement and Income Security Act, Pub L. No. 93-406, 88 Stat. 829 ("ERISA") (1974) (requirements for health insurance plans offered by private employer);

This long history of federal regulation of the health insurance market buttressed Congress's understanding that it is in a better position than the states to address that interstate market. The current patchwork of state health insurance regulations has increased complexity and costs for both insurers and the insured population. *State Coverage Initiatives: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. 28 (2008) (Trish Riley, Director, Maine Governor's Office of Health Policy & Finance) (Ex. 24). Moreover, because the federal government already provides important components of health insurance regulation — for example, Medicare and regulation of workplace-sponsored insurance through ERISA — "[e]xpecting states to address the many vexing health policy issues on their own is unrealistic, and constrains the number of states that can even make such an effort." *Id*. at 7 (Alan Weil, Exec. Dir., Nat'l Acad. of State Health Policy).

3. Congress Exercised This Constitutional Authority in Barring Insurers from Denying Coverage, or Charging Discriminatory Rates, to Those with Pre-Existing Conditions

The Act reforms insurance industry practices in the individual and small group markets that denied coverage to many by preventing insurers from denying (or revoking) coverage for those with pre-existing conditions and by preventing insurers from charging discriminatory rates to those with such conditions. ACA § 1201. Congress enacted these "guaranteed issue" and "community rating"

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 ("COBRA") (allowing certain workers who lose health benefits to continue receiving some benefits from their group health plans for a time); Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) ("HIPAA") (prohibiting group plans from discriminating against individual participants and beneficiaries based on health status, requiring insurers to offer coverage to small businesses, and limiting pre-existing condition exclusions); Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (regulating limits on mental health benefits); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (requiring maternity coverage to provide at least 48-hour hospital stay); Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 (requiring certain plans to offer benefits related to mastectomies); Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 ("MHPAEA") (parity between mental health/substance use disorder benefits and medical/surgical benefits).

reforms to address a health insurance market that had adversely affected consumers and had proven incapable of delivering affordable coverage to those who need it. Absent these reforms, the individual and small group insurance markets suffered from a market failure that prevented millions of American from obtaining necessary coverage. *See Health Reform in the 21st Century: Insurance Market Reforms*, at 53 (Dr. Blumberg).

These reforms are within Congress's commerce power. They regulate the content of policies sold in the interstate market. *See South-Eastern Underwriters*, 322 U.S. at 553. And Congress adopted them to address the multiple economic effects that result when that market cannot extend affordable coverage to those who need it: medical bankruptcies, job lock, and the shifting of the costs of medical care from the uninsured to the rest of the population. As this Court has already held, slip op. at 60, and as further shown below, Congress rationally determined that its comprehensive reforms, including the new "guaranteed issue" and "community rating" requirements, could not stand alone, and that its regulatory program required a minimum coverage provision.

4. The Minimum Coverage Provision Is an Integral Part of the Larger Regulatory Scheme and Is Necessary and Proper to Congress's Regulation of Interstate Commerce

The minimum coverage provision is a valid exercise of Congress's commerce power because it is integral to the ACA's larger regulatory program. The Act's reforms of the interstate insurance market — particularly its requirement that insurers may not deny coverage, or charge more, to individuals with pre-existing medical conditions — could not function effectively without the minimum coverage provision. As Congress expressly found, the provision is an essential part of a larger regulation of interstate commerce, and thus, under *Raich*, is well within Congress's Commerce Clause authority. *Thomas More*, 2010 WL 3952805, at *10. Analyzing the minimum

coverage provision under the Necessary and Proper Clause leads to the same conclusion for fundamentally the same reason. The provision is a reasonable means to accomplish Congress's goal of ensuring access to affordable coverage for all Americans. It is therefore necessary and proper to the valid exercise of the Commerce Clause power, and it stands on that basis as well.

a. The Minimum Coverage Provision Is Essential to the Comprehensive Regulation Congress Enacted

The minimum coverage provision is an "essential" part of the Act's larger regulatory scheme for the interstate health care market. Congress found that, absent the minimum coverage provision, these new regulations would encourage more individuals to delay or forego health insurance, thereby aggravating current problems with cost-shifting and increasing insurance prices. The new insurance regulations would allow individuals to "wait to purchase health insurance until they needed care" — at which point the ACA would obligate insurers to provide those individuals with health insurance, subject to no coverage limits based on pre-existing conditions they may have at that time. ACA §§ 1501(a)(2)(I), 10106(a). Congress found that this minimum coverage provision "is an essential part of this larger regulation of economic activity," and that its absence "would undercut Federal regulation of the health insurance market." *Id.* §§1501(a)(2)(H), 10106(a). 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).

Congress also found that, 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). Congress thus determined that 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.* These Congressional findings are amply supported. The new "guaranteed issue" and "community rating" requirements under Section 1201 of the Act help ensure that all Americans can obtain coverage. 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).

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. But coverage for this pool, self-selected and composed disproportionately of those already sick or severely injured, could not realistically be maintained. Without a minimum coverage provision, such adverse selection would drive up premiums, or reduce coverage, or both, for those who remained in the insured pool. *Health Reform in the 21st Century: Insurance Market Reforms*, at 13 (testimony of Uwe Reinhardt, Ph.D., Princeton University).[7]

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[7] This danger 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 & 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*, at 101-02 (Dr. Reinhardt). 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).

In contrast, Massachusetts enacted "guaranteed issue" and "community rating" reforms, coupled with a minimum coverage provision. Its reforms have delivered more promising results. 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.,

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. 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).[8]

Congress thus rationally found that a failure to regulate the decision to delay or forego insurance — that is, the decision to shift one's costs on to the larger health care system — would undermine the "comprehensive regulatory regime," *Raich*, 545 U.S. at 27, framed in the Act. Congress had ample basis to conclude that a failure to regulate this "class of activity" would "undercut the regulation of the interstate market" in health insurance. *Id.* at 18; *see id.* at 37 (Scalia, J., concurring in the judgment) ("Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce."); *Alabama-Tombigbee Rivers*, 477 F.3d at 1276.

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).

[8] The minimum coverage provision also addresses unnecessary costs created by medical underwriting. "By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the [minimum coverage] 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).

b. The Minimum Coverage Provision Is Also a Valid Exercise of Congress's Power Under the Necessary and Proper Clause

Because the minimum coverage provision is essential to Congress's overall regulatory reform of the interstate health care and health insurance markets, it is also a valid exercise of Congress's authority if the provision is analyzed under the Necessary and Proper Clause, U.S. Const. art. I, § 8, cl. 18. That clause is an enlargement of, rather than a limitation on, the other powers conferred on Congress under Article I: "[T]he Necessary and Proper Clause makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (quoting *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 413, 418 (1819)); *accord, e.g.*, *United States v. Belfast*, 611 F.3d 783, 804 (11th Cir. 2010). So long as Congress does not violate affirmative constitutional limitations, such as the Fourth and Fifth Amendments, the clause affords the power to employ any "means that is rationally related to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956-57 (citing *Sabri*, 541 U.S. at 605); *see Belfast*, 611 F.3d at 805 (reaffirming after *Comstock* that "[w]e, too, have recognized that the rational relationship test is an appropriate way to determine whether a federal enactment is authorized by the Necessary and Proper Clause in connection with an enumerated power"). Accordingly, "where Congress has the authority to enact a regulation of interstate commerce, 'it possesses *every power* needed to make that regulation effective.'" *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 118-19 (1942)) (emphasis added).

The Act bars insurers from denying coverage or charging higher rates based on medical conditions, including pre-existing conditions. There can be no reasonable dispute that Congress has

the power under the Commerce Clause to impose these requirements, that is, that Congress enacted the insurance market reforms in "implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1957. Nor can there be any reasonable dispute that the minimum coverage provision "constitutes a means that is rationally related to the implementation" of that power. *Id.* As this Court has already held, Congress rationally found that the minimum coverage provision not only is adapted to, but indeed is "essential" to, achieving key reforms of the interstate health insurance market. Slip op. at 60. Had Congress enacted the insurance industry reforms without the minimum coverage provision, healthy individuals would have had overwhelmingly strong incentives to forego insurance coverage, knowing that they could obtain coverage later, if and when they become ill. As a result, the cost of insurance would have skyrocketed, and the larger system of reforms would have failed. *See, e.g.*, *Health Reform in the 21st Century: Insurance Market Reforms*, at 13 (Dr. Reinhardt).

Congress thus rationally concluded that the minimum coverage provision is necessary to make the other regulations in the Act effective, and the provision is easily justified under the Necessary and Proper Clause. *See Comstock*, 130 S. Ct. at 1957 ("'If it can be seen that the means adopted are really calculated to attain the end, the degree of their necessity, the extent to which they conduce to the end, the closeness of the relationship between the means adopted and the end to be attained, are matters for congressional determination alone.'") (quoting *Burroughs v. United States*, 290 U.S. 534, 547-48 (1934)); *Belfast*, 611 F.3d at 805.

B. The Minimum Coverage Provision Regulates the Means By Which Health Care Consumption Is Financed, Which Is Quintessential Economic Activity

Even if the minimum coverage provision were considered in isolation, it would still fall within the commerce power, as the provision regulates conduct with substantial effects on interstate

commerce. Decisions about how to pay for health care, particularly decisions about whether to obtain health insurance or to attempt to pay for health care out-of-pocket, have, in the aggregate, a substantial effect on the interstate health care market.

The health care market is unique. A healthy person today cannot decide not to be "in" the market, because he cannot know what his health will be tomorrow. And individuals who forego health insurance coverage do not thereby forego health care. To the contrary, the uninsured "receive treatments from traditional providers for which they either do not pay or pay very little, which is known as 'uncompensated care.'" CBO, *Key Issues*, at 13; *see The Economic Case*, at 8. "Uncompensated care," of course, is not free of cost. In the aggregate, uncompensated costs amounted to $43 billion dollars in 2008, or about 5 percent of overall hospital revenues. CBO, *Key Issues*, at 114. These costs are in part subsidized by public funds. The federal government paid for tens of billions of dollars in uncompensated care for the uninsured in 2008 alone. H.R. Rep. No. 111-443, pt. II, at 983; *see also The Economic Case*, at 8. Other costs are borne in the first instance by health care providers, who "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; *see also* H.R. Rep. No. 111-443, pt. II, at 985; S. Rep. No. 111-89, at 2.

Furthermore, as premiums increase, more people who see themselves as healthy decide not to buy coverage. This self-selection further shrinks the risk pool and that, in turn, further increases the price of coverage for those who are insured. The result is a self-reinforcing "premium spiral." *Health Reform in the 21st Century: Insurance Market Reforms*, at 118-19 (American Academy of Actuaries); *see also* H.R. Rep. No. 111-443, pt. II, at 985.

The putative economic liberty that plaintiffs seek to champion includes the decisions of some to engage in such market timing. They will purchase insurance in later years, but choose in the short term to incur out-of-pocket costs with the backup of the emergency room services that most hospitals must provide whether or not the patient can pay. By making the economic calculation to opt out of the health insurance pool during these years, these individuals skew premiums upward for the insured population. Yet, in later years when they need care, many of these uninsured will opt back into the health insurance system maintained in the interim (if it can be maintained at all) by an insured population that has borne the costs of uncompensated care.

In the aggregate, these economic decisions regarding how to pay for health care services — including, in particular, decisions to delay or forego coverage and to pay later or, if need be, to depend on "free" care — have a substantial effect on the interstate health care market.

Congress may use its Commerce Clause authority to regulate such direct and aggregate effects. *See Raich*, 545 U.S. at 16-17; *Wickard*, 317 U.S. at 127-28. *Garcia v. Vanguard Car Rental*, 540 F.3d 1242 (11th Cir. 2008), illustrates the principle. *Garcia* rejected a challenge to congressional regulation of what the court assumed was, prior to aggregation, an intrastate matter, strict liability state tort rules for rental car accidents. *Id.* at 1250-51. Because those rules, at least in the aggregate, would lead to cost-shifting in the interstate car rental market, the Court of Appeals explained that Congress had authority under the Commerce Clause to pre-empt those rules of decision. *Id.* at 1253.

C. Plaintiffs' Attempt To Characterize Decisions To Forego Insurance As "Inactivity" Does Not Immunize Those Decisions from Regulation Under The Commerce Clause

In attempting to push aside the unique practical aspects of the health care market, which prompted Congress to pass the ACA, plaintiffs advance an abstract categorical argument. They argue that decisions not to buy insurance amount to "inactivity," and that inactivity, "by its nature," is not intrastate commerce and cannot even have so much as an "effect on commerce," and therefore can never be "subject to Congress's powers under the Commerce Clause." Am. Compl. ¶ 71. This sweeping assertion misunderstands both the nature of the regulated activity and the broad scope of Congress's power.

First, as Congress found, the decision to try to pay for health care services without reliance on insurance is "economic and financial." ACA §§ 1501(a)(2)(A), 10106(a). It certainly is for plaintiff Brown, who will explicitly decide whether buying insurance for herself is a "worthwhile cost of doing business." Am. Compl. ¶ 62. As we have shown above, health insurance is not an independent consumer product, but a means of managing the economic risks inherent in a market for health care services in which almost everyone inevitably participates.

The minimum coverage provision regulates paradigmatic economic activity — the way that health care is financed. Individuals who make the economic choice of means other than insurance to finance their medical expenses have not opted out of health care; they are not passive bystanders divorced from the *health care market*. *Thomas More*, 2010 WL 3952805, at *9. To the contrary, the vast majority of even the long-term uninsured still participate in the health care market. *See* O'Neill & O'Neill, *Who Are the Uninsured?*, at 14-15. And those individuals do not sit passively in relation to the insurance market either. Instead, individuals repeatedly make economic decisions whether to finance their medical needs through insurance, or to attempt to do so out-of-pocket with

the backstop of uncompensated care. Indeed, a substantial majority of those without insurance coverage at some point during any given year had moved in or out of coverage and had coverage at some other point within the same year. CBO, *How Many Lack Health Insurance and For How Long?* at 4, 9 (May 2003); *see also* CBO, *Key Issues*, at 11.

The decision whether to purchase health insurance on the open market is thus a decision about how to pay for health care consumption during a particular time period. The purchase of insurance is an economic substitute for other "competing pre-loss risk-financing methods." *See* M. Moshe Porat et al., *Market Insurance versus Self Insurance: The Tax-Differential Treatment and Its Social Cost*, 58 J. Risk & Ins. 657, 668 (1991) (Ex. 30). Individuals who are able to purchase insurance on the open market but do not do so instead use other economic means to attempt to pay for the health care they consume. These individuals "self-insure, use informal risk-sharing arrangements, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services." Ruger, 100 Q.J. Med. at 55. These actions reflect an economic assessment of the relevant advantages of market insurance versus other means of attempting to pay for health care services in a particular period. Pauly, 26 Health Affairs at 658.

However, there are inherent uncertainties, unique to the health care market, in the "frequency, timing, and magnitude" of illness and accidents, Ruger, 100 Q.J. Med. at 54-55, and Congress found that individuals who attempt to finance their health care costs through these alternative mechanisms are routinely unable to do so and instead shift costs to other participants in the health care market. As noted above, by even a conservative estimate, in 2008 alone, $43 billion in health care costs were shifted from the uninsured to other participants in the health care market, including providers, insurers, consumers, governments, and, ultimately, taxpayers. To discourage these methods of health care financing that have been shown to be inadequate and that

systematically result in uncompensated care, and to forestall the economic consequences of these financing decisions, Congress, in the minimum coverage provision, required non-exempted individuals either to maintain a certain level of insurance or to pay a penalty.

Like the currently insured, persons subject to this requirement, who finance their health care consumption without purchasing insurance, are engaged in economic activity to an even greater extent than the plaintiffs in *Wickard* or *Raich*. In *Wickard*, for example, the Court upheld a system of production quotas, despite the plaintiff farmer's claim that the statute was effectively "*forcing some farmers into the market* to buy what they could provide for themselves." 317 U.S. at 129 (emphasis added). The Court reasoned that "[h]ome-grown wheat in this sense competes with wheat in commerce. The stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon." *Id.* at 128; *see id.* at 127 ("The effect of the statute before us is to restrict the amount which may be produced for market and the extent as well to which one may forestall resort to the market by producing to meet his own needs"); *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258-59 (1964) (Commerce Clause reaches decisions not to engage in transactions with persons with whom plaintiff did not wish to deal); *Daniel v. Paul*, 395 U.S. 298 (1969) (same). And in *Raich*, the plaintiffs likewise claimed that their home-grown marijuana was "entirely separated from the market" and thus not subject to regulation under the Commerce Clause. The Court rejected their claim as well. 545 U.S. at 30.

In light of these authorities, the uninsured — whose conduct, in the aggregate, substan-tially affects interstate commerce by shifting the cost of their care to other parties — cannot avoid Commerce Clause regulation by characterizing their conduct as a decision to remain outside of interstate channels. The courts, for example, have rejected comparable challenges to the Child Support Recovery Act, 18 U.S.C. § 228(a), which affirmatively requires parties to send child support

payments in interstate commerce. *E.g.*, *United States v. Williams*, 121 F.3d 615, 618-19 (11th Cir. 1997). Conduct that substantially affects interstate commerce is subject to congressional regulation, even if it may be characterized as a failure to act. *See United States v. Ambert*, 561 F.3d 1202, 1210-12 (11th Cir. 2009) (under Commerce and Necessary and Proper Clauses Congress may regulate failure to register as a sex offender). Congress also has the power to require private parties to enter into insurance contracts where the failure to do so would impose costs on other market participants. Under the National Flood Insurance Program, for example, an owner of property — including a residence or other non-commercial property — in a flood hazard area must obtain flood insurance in order to obtain a mortgage or other secured loan from any regulated financial institution. 42 U.S.C. § 4012a(a), (b), (e).[9]

The Congressional authority to protect interstate commerce, both by prohibiting and by requiring conduct, is also central to modern environmental regulation. Under the Superfund Act, or CERCLA, 42 U.S.C. § 9601 *et seq.*, "covered persons," including property owners (whether or not they are engaged in commercial activity), are deemed by the statute to be responsible for environmental damage from the release of hazardous substances. Such persons are subject to monetary liability, and may be ordered to engage in remediation efforts. 42 U.S.C. §§ 9606-07. The statute imposes a strict liability regime. A current property owner is subject to CERCLA as a "covered person," and may therefore be subject to a remediation order, without any showing that he caused the contamination. 42 U.S.C. § 9607(a). And even a former property owner may be

[9] Other examples of federal mandates that market participants buy insurance abound. *E.g.*, 6 U.S.C. § 443(a)(1) (sellers of anti-terrorism technology); 16 U.S.C. § 1441(c)(4) (entities operating in national marine sanctuary); 30 U.S.C. § 1257(f) (surface coal mining and reclamation operators); 42 U.S.C. § 2210(a) (nuclear power plant operators); 42 U.S.C. § 2243(d)(1) (uranium enrichment facility operators); 42 U.S.C. § 2458c(b)(2)(A) (aerospace vehicle developers); 45 U.S.C. § 358(a) (railroad unemployment insurance); 49 U.S.C. § 13906(a)(1) (motor carriers).

subject to CERCLA as a "covered person," even if he only permitted hazardous waste to leak on his property "without any active human participation." *Nurad, Inc. v. William E. Hooper & Sons Co.*, 966 F.2d 837, 845 (4th Cir. 1992). The property owner's characterization of his own behavior as "active" or "passive" is irrelevant; otherwise, "an owner could insulate himself from liability by virtue of his passivity," defeating the remedial purposes of the Superfund Act. *Id.* Congress's authority to enact the Superfund Act — including its authority to regulate behavior that a creative defendant could characterize as "passivity" — is well-established, because, in the aggregate, releases of hazardous substances have a substantial effect on interstate commerce. *See Olin Corp*., 107 F.3d at 1510-11.

In any event, even if the Act could be properly characterized as regulating "inactivity," there is no "activity" clause in the Constitution. Plaintiffs attempt to create such a constitutional requirement by focusing on the word "activity" in Supreme Court cases under the Commerce Clause. Pls.' Opp'n to Defs.' Mot. Dism. 25-27. But the critical distinction between cases like *Wickard* and *Raich* on the one hand and *Morrison* and *Lopez* on the other has nothing to do with plaintiffs' proposed distinction between activity and inactivity. Those cases instead turn on the difference between *economic* and *non-economic* regulation. They used the word "activity" because economic activity is what was at issue there. Similarly, at one point in our history, the prior Supreme Court cases had all spoken in terms of movement of goods, from which it might be — and by some was — inferred that interstate movement or an effect on movement was part of the constitutional test. *See* Robert L. Stern, *That Commerce Which Concerns More State Than One*, 47 Harv. L. Rev. 1335, 1360-61 (1934). But in those cases "the Court talked about movement because that was all it needed to talk about to decide the cases before it." *Id*. at 1361. As would soon become apparent, "movement" may have described the facts of the prior cases, but not the limits of

the Constitution: "The congressional authority to protect interstate commerce from burdens and obstructions is not limited to transactions which can be deemed to be an essential part of a 'flow' of interstate or foreign commerce. Burdens and obstructions may be due to injurious action springing from other sources. The fundamental principle is that the power to regulate commerce is the power to enact 'all appropriate legislation' for its 'protection or advancement.'" *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 36-37 (1937) (citations omitted). So too here. That the prior cases happened to involve "activity" sheds no light on whether Congress may reach inactivity if necessary and proper to its regulation of commerce.

Nor is there any general bar on the federal government's compelling a citizen to act. Even plaintiffs are forced to acknowledge that, in the exercise of enumerated powers *other* than the Commerce Clause, Congress may compel, and has compelled, activity. Pls.' Opp'n to Defs.' Mot. Dism. 31-32 n.34; *see, e.g.*, Second Militia Act of 1792, ch.38, § 1, 1 Stat. 264, 265 (requiring all free men to obtain firearms, ammunition, and other equipment). But plaintiffs deny that this is so with respect to the Commerce Clause, which becomes under their theory a second-class enumerated power that cannot, even in combination with the Necessary and Proper Clause, authorize the federal government to compel activity. *See id.*

Such second-class status cannot be justified. The commerce "power, like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." *Gibbons v. Ogden*, 22 U.S. 1, 196 (1824). Such exercise can include compelling activity where necessary and proper. Consider, for example, one of the affirmative duties imposed by the First Congress, *see* Judiciary Act of 1789, ch. 20, § 27, 1 Stat. 73, 87 — the "duty[ ] of every citizen, when called upon by the proper officer, to act as part of the posse comitatus in upholding the laws of his country." *In re Quarles*, 158 U.S. 532, 535

(1895). This duty can arise in conjunction with upholding a law passed under the Commerce Clause just as it might with any other federal power.[10] A further example: Contrary to plaintiffs' argument that the Commerce Clause and Necessary and Proper Clause can never be used to compel someone to "buy — or sell — particular goods or services," Pls.' Opp'n to Defs.' Mot. Dism. 27, Congress may use eminent domain to force the sale of land where necessary to the regulation of commerce. *Luxton v. N. River Bridge Co.*, 153 U.S. 525, 529-30 (1894).

That the minimum coverage provision is constitutional does not eliminate limits on what subjects the Congress may address under the Commerce Clause. The limitations here derive from the unique combination of features that characterize the health care market. The near universal participation in that market, the unpredictable risks of incurring enormous medical expenses, the requirement that hospitals provide care regardless of ability to pay, and the prevalence and enormous impact of cost shifting, yield an airtight connection between the minimum coverage provision and interstate commerce, a connection replicated in no other market. The centrality of the minimum coverage provision to the ACA's insurance industry reforms places the provision well within the boundaries of the Necessary and Proper clause. In short, there is no basis to accept plaintiffs' invitation to hobble the authority of Congress to address what, as here, *is* a quintessentially economic subject with a formalistic immunity from regulation for anyone who can, for the moment, claim to be inactive.

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[10] *See* Letter from Secretary of State James Madison to John Willard (April 19, 1808), *in* Department of State, *Domestic Letters Sent, 1793-1906*, Microfilm Collection M-40, National Archives and Records Administration, Washington, D.C. (in light of "forceable attempts . . . about to be made . . . to frustrate the execution of the Embargo" Act, President Jefferson "require[d]" the Marshal in Vermont to "render . .. by means of [his] posse all the aid which the occasion may require"); The Federalist No. 29 (Alexander Hamilton) (service in posse could be required as necessary and proper to execute federal government's "declared powers").

D. The Asserted Novelty of the Minimum Coverage Provision Does Not Place It Beyond the Reach of the Commerce Power

Plaintiffs seek to disregard, or even invert, the strong presumption that legislation adopted by the democratically elected branches of government is constitutional. They do so based on the assertion that the minimum coverage provision is a "novel exercise of power." Pls.' Opp'n to Defs.' Mot. to Dism. 31. Any new law is by definition to some degree novel. As we explain above, however, clear precursors of the minimum coverage provision can be found in, *inter alia*, federal regulation of health care, of insurance, and of health care insurance specifically.

But even if it were otherwise, the novelty of a law does not diminish the presumption of constitutionality. Necessarily, regulation under the Commerce Clause adapts to the changing nature of the commerce being regulated. A century after the framing, for example, the Court explained:

> The powers thus granted are not confined to the instrumentalities of commerce, or the postal service known or in use when the Constitution was adopted, but they keep pace with the progress [of] the country, and adapt themselves to the new developments of time and circumstances. They extend from the horse with its rider to the stage-coach, from the sailing-vessel to the steamboat, from the coach and the steamboat to the railroad, and from the railroad to the telegraph, as these new agencies are successively brought into use to meet the demands of increasing population and wealth. They were intended for the government of the business to which they relate, at all times and under all circumstances.

Pensacola Tel. Co. v. W. Union Tel. Co., 96 U.S. 1, 9 (1877).

The federal government did relatively little until the latter part of the nineteenth century to affirmatively regulate interstate commerce. When Congress thereafter did "f[ind] it necessary to regulate additional specific abuses . . . [e]ach new type of statute, when passed, seemed novel and dangerous." Stern, 47 Harv. L. Rev. at 1350-51. Yet "the Court kept pace with [Congress] in recognizing the need for extending the application of the commerce power." *Id.* at 1351. The courts' openness to novel exercises of the Commerce Clause power is not a relic of the past. Only two years ago, the Eleventh Circuit upheld a statute as a valid exercise of the commerce power

despite recognizing that the theory under which Congress acted was "relatively novel" because the challenged statute was itself "novel." *Garcia*, 540 F.3d at 1252-53.

Thus, while the ACA is in fact consistent with prior exercises of authority under the Commerce Clause, the point is that it is the job of Congress, not the courts, to determine the appropriate response to an unprecedented economic crisis in the health care market that accounts for one sixth of the American economy. Once Congress has made that determination, be it novel or not, the Court must accord it substantial deference.

II. THE AMENDMENTS TO MEDICAID FALL WITHIN THE SPENDING POWER

In Count Four, the State plaintiffs allege that the ACA's amendments to the Medicaid program exceed Congress's Article I powers and violate the Ninth and Tenth Amendments. Relying solely on the discredited "coercion" theory, they claim they have "no choice" but to accede to these amendments, even though doing so will "run [their] budgets off a cliff," because of the size or importance of federal Medicaid grants. Slip op. at 50, 52. This claim has three independent flaws, each of which is fatal. First, when viewed in the context of the full Act, the amendments will not harm state budgets; to the contrary, any increases in state Medicaid spending will be more than offset by new savings created by the ACA. Second, the coercion theory provides no judicially administrable standards and essentially raises political questions that fall outside the province of the judiciary, as several courts have held. Third, even if this claim were justiciable, the ACA's Medicaid amendments do not cross the line separating "pressure" from "coercion," wherever it may be.

Many courts have considered indistinguishable claims about the allegedly coercive effect of conditional spending programs, including Medicaid. Yet no court — *ever* — has invalidated a spending condition on this theory. This Court should decline to be the first.

A. The Medicaid Program

Title XIX of the Social Security Act established Medicaid as "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). Although state participation is voluntary, in order to receive the hundreds of billions of dollars Congress has appropriated, states that elect to participate must satisfy the conditions Congress has prescribed. *Id.*[11] As plaintiffs recognize, participating states have retained "considerable discretion to implement and operate their respective Medicaid programs in accordance with State-specific designs regarding eligibility, enrollment, and administration." Am. Compl. ¶ 40.

B. The ACA's Amendments to Medicaid

This Court has recognized the "simple and unassailable fact" that "state participation in Medicaid under the [ACA] is, as it has always been, entirely voluntary." Slip op. at 51. Thus, if a state determines that continued participation is no longer in its interests, it retains "the freedom to opt out of the program." *Id.* The Court has also recognized that Congress "expressly reserved the right to alter or amend the [Medicaid] program," *id.* (citing 42 U.S.C. § 1304), and, "in fact, . . . has done so numerous times over the years," *id.* — in particular, to expand eligibility. *See* 42 U.S.C. § 1396a note; *Bowen v. POSSE*, 477 U.S. 41, 53 (1986) (states enter Medicaid subject to, and on notice of, Congress's authority to amend the program); John Klemm, Ph.D., *Medicaid Spending:*

[11] Procedurally, to be eligible for federal Medicaid matching funds, a state must submit to the Secretary of Health and Human Services ("HHS") a plan demonstrating compliance with statutory and regulatory requirements. *See* 42 U.S.C. § 1396a. If the Secretary approves the plan, the federal government reimburses part of the state's covered Medicaid expenditures. This "federal medical assistance percentage" ("FMAP") has ranged from 50 to 83 percent. *Id.* § 1396d(b). The American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009), temporarily increased FMAPs above these levels to provide States fiscal relief and to support Medicaid during the economic downturn. The federal government also pays at least 50 percent of the State's administrative costs for Medicaid. *See* 42 U.S.C. § 1396b(a)(2)-(5), (7).

A Brief History, 22 Health Care Fin. Rev. 106 (Fall 2000) (Ex. 31) (between 1966 and 2000, Medicaid enrollment expanded from 4 million to 33 million).

For example, in 1972, Congress generally required participating states to extend Medicaid to recipients of Supplemental Security Income, dramatically expanding overall enrollment. *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972). In 1989, Congress required states to extend Medicaid to pregnant women and children under age six who meet certain income limits. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989). The ACA similarly expands Medicaid eligibility to include individuals under age 65 with incomes below 133 percent of the federal poverty level. ACA § 2001(a)(1). Congress also addressed the medical care and services that must be covered, providing that these newly eligible adults must be offered a "benchmark" benefits plan that contains the same minimum essential coverage required of plans sold on state exchanges. *Id.* § 2001(a)(2). These amendments will take effect in 2014. *Id.* § 2001(a)(1).

Unlike past Medicaid expansions, where the federal medical assistance percentage for some states was as low as 50 percent, the federal government will reimburse states for 100 percent of benefits paid to newly eligible recipients from 2014 to 2016. *Id.* § 2001(a)(3)(B); HCERA § 1201. That percentage will gradually decrease — to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019 — leveling off at 90 percent thereafter. HCERA § 1201. *Id.* Accordingly, the CBO estimates that, under the ACA, federal Medicaid outlays will increase by $434 billion, and state outlays by $20 billion, through the end of the decade. Letter from Douglas Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps. tbl.4 (Mar. 20, 2010) (Ex. 32) [herein-after CBO Letter to Speaker Pelosi]. However, just as the increased federal Medicaid outlays are expected to be offset by other revenue-generating and cost-saving provisions of the

ACA, so too will any increased state outlays, as explained below. CEA, *The Impact of Health Insurance Reform on State and Local Governments*, at 7-8 (Sept. 15, 2009) (Ex. 33) [hereinafter "*The Impact on States*"].

C. Plaintiffs' Coercion Claim Is Meritless

Plaintiffs do not dispute that, under the Spending Clause, 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," *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). Plaintiffs also do not dispute that the Act's amendments to Medicaid satisfy the four "general restrictions" on the spending power set forth in *Dole*. Slip op. at 52 (citing *id.* at 207-10). Instead, their "coercion" claim rests entirely on the notion that, although Congress expressly reserved the right to amend Medicaid — and although states' continued participation in the program remains voluntary — the Act's amendments leave them "no choice" but to participate. *Id.* at 52 (citing Am. Compl. ¶ 84). In short, plaintiffs contend that Congress has offered them a Hobson's choice: either accept the Medicaid amendments, which they claim they cannot afford, or exit the Medicaid program, and decline federal matching funds that subsidize medical care for their low-income residents. *Id.* at 50, 52. Plaintiffs ask the Court to relieve them of this choice and, instead, to permit them to dictate to Congress the conditions under which federal Medicaid funds will be provided. This claim should be dismissed for three independent reasons.

1. The Medicaid Expansion Will Help, Not Harm, State Budgets

Plaintiffs' claim that the Medicaid expansion will "run [their] budgets off a cliff" is inaccurate. Credible projections indicate that any increase in state Medicaid spending will be dwarfed by new federal spending, and will be more than offset by new ACA-created savings.

a. Any Increase in State Spending Will Be Small in Comparison to New Federal Spending and the Dramatic Reduction in the Ranks of the Uninsured

The Congressional Budget Office estimates that the Medicaid expansion will increase state Medicaid outlays by $20 billion over the next decade. CBO Letter to Speaker Pelosi tbl.4. That increase pales in comparison to the estimated $434 billion in new federal Medicaid spending over the same period. *Id.* Overall, the federal government will shoulder more than 95 percent of all new Medicaid spending over the next decade, *see id.* — much higher than typical federal matching rates.

In exchange for these relatively small outlays, states stand to reap huge benefits in the form of improved coverage and a sharp reduction in the number of both uninsured residents and residents now covered by state-funded programs. The CBO estimates that the expansion will increase Medicaid enrollment by about 16 million by 2019. *Id.* A recent study found that, on average, that will reduce by 44.5 percent the number of uninsured adults below 133 percent of the federal poverty level ("FPL") (currently $14,404 for an individual). Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 10 tbl.1 (May 2010) (Ex. 34).

Actual coverage increases will vary from state to state. For example, in Florida, the federal government is expected to pay for 94.2 percent of the expansion, and the number of uninsured adults below 133 percent of FPL is expected to decline by 44.4 percent, in line with the national average. *Id.* Other states will likely see greater benefits, depending on current levels of coverage. In South Carolina, the federal government is expected to pay for 95.9 percent of the expansion, while the number of uninsured adults below 133 percent of FPL should decrease by 56.4 percent. *Id.*

Moreover, for an accurate picture of the expansion's effect on state budgets, any increases in state Medicaid spending must be viewed in comparison to baseline projections in the absence of

reform. By that measure, by the end of the decade, average state Medicaid spending under the ACA is expected to increase just 1.4 percent. *Id.*

b. Any Increase in State Spending Will Be More than Offset by New Savings under the ACA

Moreover, credible projections indicate that even this small increase in state Medicaid spending will be more than offset by other ACA provisions not accounted for in the numbers above. In many respects, new federal spending will substitute for existing state spending on the uninsured:

- *Savings on state-funded programs covering the newly Medicaid-eligible*. 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. For example, 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. Indiana subsidizes coverage for a similar population through its Healthy Indiana Plan for about $155 million per year, and separately funds millions in emergency care for the indigent. *Id.* at 34-35. Under the ACA, many of these individuals will be eligible for Medicaid — at enhanced federal matching rates — vastly reducing state expenditures.

- *Savings on state-funded programs covering those eligible for subsidies on exchanges*. Like Pennsylvania and Indiana, many states also currently subsidize health care for those between 133 percent and 400 percent of FPL using only state or local funds. Under the ACA, those individuals will be eligible for federal subsidies through exchanges — at no cost to the states — enabling states to further reduce current costs. *See id.* at 34-35, 85.

- *Savings on state-funded high-risk pools*. 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. Under the ACA, those individuals will be eligible for coverage through exchanges, without excessive premiums, enabling states to save millions of dollars in funding. *Id.* at 29, 35, 67.

- *Reduced cost-shifting onto state governments*. By reducing the number of uninsured Americans, the ACA will curtail the amount of uncompensated care borne by state and local governments. For example, 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 but may be unnecessary under the ACA. CEA, *The Impact on States*, at 24. Moreover, as previously discussed, cost-shifting creates a "hidden tax" on the premiums of insured individuals — some of which is borne by employers, including governments. Under the ACA, it is estimated that state and local governments will recoup up to $1.6 billion of this "hidden tax" per year. *Id.* at 6.

These examples are representative, not exhaustive.[12] Taken together, the savings that will accrue to states from just two areas — (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. This will easily offset the $20 billion increase in state Medicaid outlays expected to accrue over a *full decade*. *Id.* at 6-7. Florida alone is projected to save $377 million per year. *Id.* at 6, 26.

Governments do not write budgets for individual line items; their budgets are the sum of a number of moving parts. When Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions. Likewise, any increase in state Medicaid outlays under the Act should not be viewed in isolation, but in the context of the Act's other provisions that affect state budgets. Seen in that light, they are likely to help, not harm, the states' bottom lines.

2. Plaintiffs' Coercion Claim is Not Fit for Judicial Resolution

As this Court has recognized, "there is 'no decision from *any* court finding a conditional grant to be impermissibly coercive.'" Slip op. at 55 (quoting *West Virginia v. U.S. Dep't of Health*

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[12] *See also, e.g.*, John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [ACA] on the States?*, at 2 (June 2010) (Ex. 35) ("[S]tate and local governments would save approximately $70-80 billion over the 2014-2019 period by shifting [currently state-funded coverage] into federally matched Medicaid, clearly exceeding the new cost to the states of 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) ("[S]tates' savings from no longer having to finance as much of the cost of providing uncompensated care to the uninsured *may fully offset* the small increase in Medicaid costs resulting from the Medicaid expansion."); Kaiser Family Foundation, *Health Reform Issues: Key Issues About State Financing and Medicaid*, at 3 (May 2010) (Ex. 37) (increases in federal Medicaid funding will generate economic activity at the state level, including jobs and state tax revenues). *Cf., e.g.*, 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) (absent reform, state Medicaid/CHIP spending estimated to increase 60.7 percent by 2019 even under best-case scenario).

& Human Servs., 289 F.3d 281, 289 (4th Cir. 2002) (emphasis added)). Indeed, after canvassing the "almost uniformly hostile" reaction to the coercion theory among the Courts of Appeals, *id.* at 53, this Court expressed doubt that the theory even "stands at all," but concluded that, if it does, it is "on extremely 'wobbly legs.'" *Id.* (quoting *Nevada v. Skinner*, 884 F.2d 445, 454 (9th Cir. 1989)). Those legs are but "a single sentence [in] *Dole*, where the Supreme Court speculated that 'in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which "pressure turns into coercion,"'" *id.* at 52 (quoting *Dole*, 483 U.S. at 211), and similarly speculative language in *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937), where the Court held that, even "*if we assume* that such a concept can ever be applied with fitness to the relations between state and nation," the "point at which pressure turns into compulsion" had not been met, *id.* at 590 (emphasis added).

Thus, to prevail on their coercion claim, Plaintiffs must demonstrate not only that the hypothetical line separating "pressure" from "coercion" has been crossed. *Id.* They must also, as an initial matter, show that the coercion theory "can ever be applied with fitness to the relations between state and nation." *Id.* Both *Steward Machine* and *Dole* strongly suggest that it cannot.

In *Steward Machine*, the Court recognized that every federal spending statute "is in some measure a temptation," and cautioned that "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." 301 U.S. at 589-90. Thus, in articulating the coercion theory, the Court as much as doomed it, explaining: "The outcome of such a doctrine is the acceptance of a philosophical determinism by which choice becomes impossible." *Id.* at 590. *Dole* followed this logic, reaffirming the assumption, founded on "'robust common sense,'" that States exercise "'the freedom of the will'" when they choose whether to accept the conditions attached to the receipt of federal funds. *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590).

Accordingly, some Courts of Appeals have applied *Steward Machine* effectively to bar coercion challenges to conditional spending programs. For example, the D.C. Circuit considered *Steward Machine* an "admonish[ment]" that "courts should attempt to avoid becoming entangled in ascertaining the point at which federal inducement to comply with a condition becomes compulsion," and concluded that "[t]he courts are *not suited* to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice." *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981) (emphasis added). The First Circuit, following *Steward Machine*, categorically rejected the theory that conditional spending programs can be considered "'coercive' in the constitutional sense" because of the "severe financial consequences" that would follow a State's refusal to participate. *N.H. Dep't of Empl. Sec. v. Marshall*, 616 F.2d 240, 246-47 (1st Cir. 1980). The court explained: "It is not the size of the stakes that controls, but the rules of the game." *Id.* at 246.

And most Courts of Appeals that have not flatly rejected the coercion theory have expressed grave doubts about its viability. The Eighth Circuit has held that "[s]overeign states are fully competent to make their own choice" whether to decline conditional federal funding; such choices, though "politically painful," are simply not "unconstitutionally 'coercive.'" *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000). The Ninth Circuit has described the theory as "highly suspect as a method for resolving disputes between federal and state governments" given the "difficulty if not impropriety of of making judicial judgments regarding a state's financial capabilities." *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989). And the Tenth Circuit has said the theory is "unclear, suspect, and has little precedent to support its application." *Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000). Even the Fourth Circuit — the lone circuit where the theory may retain some vitality, although only in circumstances not present here — has acknowledged the prevailing view

that, "in essence, . . . the theory raises political questions that cannot be resolved by the courts." *West Virginia*, 289 F.3d at 289.

This conclusion, presaged by *Steward Machine* itself, is an inevitable consequence of the theory's lack of judicially administrable standards. Despite 70 years of hypothetical existence, it still lacks "any principled definition." *Nevada*, 884 F.2d at 448. If a line could indeed be drawn between "pressure" and "coercion," what standards would mark its location? As the Ninth Circuit has asked:

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

Id. Plaintiffs offer no principled approach to answering these myriad questions.

Moreover, any attempt to do so would draw the Court into a dense factual thicket, requiring it to settle policy questions that fall decidedly outside its bounds of expertise. Where a nationwide spending program is concerned, "[e]ven a rough assessment of the degree of temptation would require extensive and complex factual inquiries on a state-to-state basis." *Oklahoma*, 655 F.2d at 414. Plaintiffs allege that Florida spends 26 percent of its budget on Medicaid, Am. Compl. ¶ 51; that federal grants typically reimburse 55 percent of those expenditures, *id.* ¶ 52; and that "Florida's circumstances . . . fairly represent the nature of the burdens the Act imposes on the Plaintiff States," *id.* ¶ 49. But that is a dramatic oversimplification. The nature and scope of state Medicaid programs — like many federal spending programs — vary significantly. *See, e.g.*, *West Virginia*, 289 F.3d at 287 (describing one state as "unusually dependent on federal Medicaid dollars" given its above-average participation rate). The same is true of the degree to which states subsidize health care for their low-income citizens, and how they finance those policy decisions. *See* Kaiser Comm'n on

Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 1 (there is a "great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership, and priorities"). A few examples illustrate these points.

Assume that three factors are relevant to the coercion inquiry: (1) the size of the federal grant at stake; (2) the proportion of the state program that the federal grant represents; and (3) the proportion of the state's total revenues that the federal grant represents. *Cf. Van Wyhe v. Reisch*, 581 F.3d at 650-51 (considering these factors). With respect to the first, in fiscal year 2008, federal Medicaid grants ranged from $246 million (Wyoming) to $23.8 billion (New York) — nearly a 100-fold difference. Kaiser Family Foundation, *Federal & State Share of Medicaid Spending*, FY2008 (Ex. 39). Second, using FMAPs as a proxy, the proportion of state Medicaid expenditures funded by federal dollars ranged from 50 percent (several states, including Colorado) to 76 percent (Mississippi). 71 Fed. Reg. 69209, 69210 (Nov. 30, 2006). And third, state spending on Medicaid, as a proportion of total state revenues, ranged from 8.4 percent (Alaska) to 34.5 percent (Missouri) — meaning that the proportion of total state revenues formed by federal Medicaid grants ranged from 4.4 percent (Alaska) to 21.5 percent (Missouri). 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]. Plainly, then, the benefits and obligations of Medicaid participation affect states in quite different ways, and Florida's circumstances are by no means "representative" of anything. Indeed, by these measures, a conditional spending program might be "coercive" to one state, but not to another — its fate hanging only on which state chose to sue.

What is more, these factual differences largely reflect varying policy choices — made at the *state* level — about the level of health care to provide and how to fund that care. Before the ACA, some states set relatively restrictive Medicaid eligibility requirements, *see* 42 U.S.C. § 1396a(a)

(10)(A)(i) (requiring coverage of the "categorically needy"), and thus minimized their health care spending — for example, Mississippi, which in fiscal year 2008 spent only 11 percent of its budget on Medicaid. NASBO Report at 10 tbl.5. Others extended Medicaid eligibility well beyond the minimum requirements and thus collected additional federal matching funds, *id.* § 1396a(a)(10)(A)(ii) — such as Pennsylvania, which spent more than 30 percent of its budget on Medicaid. NASBO Report at 10 tbl.5. Still others, including Florida, provide subsidized care outside of Medicaid, funded entirely with state or local dollars. CEA, *The Impact on States*, at 23-26. These disparate approaches depend, of course, on "how the state and its localities share funding responsibilities for public services and how much state policymakers choose to invest in health care, education, and other programs." Center on Budget & Policy Priorities, *Policy Basics: Where Do Our State Tax Dollars Go?*, at 3 (Mar. 19, 2010) (Ex. 41).

These differences also depend on how each state's citizens, acting through their elected representatives, choose to raise revenue to fund state expenditures, including health care. Each state is, of course, "free to change its method of generating public income whenever [its] people wish to do so." *Nevada*, 884 F.2d at 448 n.5. The vast majority of states collect personal income, corporate income, and sales taxes. But 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* (Ex. 42). Three (Nevada, Texas, and Washington) impose no corporate income tax. *Id.* And one (Alaska) imposes no sales tax. *Id.* In fact, 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 Adm'rs, *2009 State Tax Revenue* (Ex. 43). The point here is not to applaud or assail particular states for their tax policies. Nor is it to suggest that they raise taxes to implement the Medicaid expansion — as shown, that is unnecessary. Rather, it

is to underscore the serious doubts that "a sovereign state which is always free to increase its tax revenues [can] ever be coerced by the withholding of federal funds." *Nevada*, 884 F.2d at 448.

At bottom, to ask whether the benefits of a federal grant are outweighed by the strings attached is to raise "questions of policy and politics that range beyond [the courts'] normal expertise." *Id.* Indeed, they are, "in essence, . . . political questions that cannot be resolved by the courts" and belong, instead, in the hands of the people and their elected representatives. *West Virginia*, 289 F.3d at 289; *see Baker v. Carr*, 369 U.S. 186, 217 (1962) (political question may be found based on "a lack of judicially discoverable and manageable standards for resolving it" or "the impossibility of deciding without an initial policy determination of a kind clearly for nonjudicial discretion"). Until now, courts have properly abstained from drawing this line, because there is no principled way to draw it. The coercion theory simply cannot "be applied with fitness to the relations between state and nation." *Steward Machine*, 301 U.S. at 590.

3. Even if This Claim Is Justiciable, the ACA's Medicaid Provisions Are Not Coercive

Even if the Court concludes that the coercion theory can be "applied with fitness" here, the point at which "pressure turns into compulsion" has not been reached. As noted earlier, courts considering this theory have looked to three factors: (1) the size of the federal grant at stake; (2) the proportion of the state program that the federal grant represents; and (3) the proportion of the state's total revenues that the federal grant represents. But by any measure, no court has *ever* invalidated *any* conditional spending program as coercive — including Medicaid. Rather, states are "ultimately free to reject both the conditions and the funding, no matter how hard that choice may be," *Kansas*, 214 F.3d at 1203, and that freedom is not rendered illusory by the size of the grant or its importance to state finances, *Oklahoma*, 655 F.2d at 414.

Thus, the courts have uniformly rejected claims of coercion no matter how large the federal grant — even where, as here, the *entire* federal grant is at stake. *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (entire Medicaid grant); *Padavan v. United States*, 82 F.3d 23, 29 (2d Cir. 1996) (entire Medicaid grant); *Oklahoma*, 655 F.2d at 414 (entire Medicaid grant); *Jim C.*, 235 F.3d at 1082 (entire federal education grant); *Kansas*, 214 F.3d 1198 (entire federal welfare grant); *Van Wyhe*, 581 F.3d at 652 (entire federal grant for state prisons); *Nevada*, 884 F.2d at 448-49 (95 percent of federal highway grant).

Likewise, the courts have uniformly rejected coercion claims no matter what proportion of the state program the federal grant supports. *Kansas*, 214 F.3d at 1198 (federal grant funds 66 to 80 percent of state program); *Doe v. Nebraska*, 345 F.3d 593, 598 (8th Cir. 2003) (60 percent of state program); *Jim C.*, 235 F.3d at 1082 (12 percent of state program); *Van Wyhe*, 581 F.3d at 652 (9 to 17 percent of state program). Indeed, *Steward Machine* itself rejected a coercion claim where the states stood to lose up to a 90 percent share of federal unemployment taxes. 301 U.S. at 585-93. In that case, the Supreme Court upheld the unemployment compensation provisions of the Social Security Act of 1935, which were designed to encourage the states to create unemployment insurance funds meeting federal standards. Those provisions imposed a federal tax on employers, but allowed up to a 90 percent credit against that tax for payments made to a state unemployment insurance fund. *Id.* at 574. The provisions had the desired effect, inducing 38 states to create unemployment insurance funds, *id.* at 587-88, on pain of losing their share of the hundreds of millions of tax dollars that would otherwise flow to the federal government, *id.* at 585 n.8. Nevertheless, the Court rejected the argument that this taxing structure "destroy[ed] or impair[ed] the autonomy of the states." *Id.* at 586; *see also Florida v. Mellon*, 273 U.S. 12 (1927) (rejecting

claim that states were unconstitutionally "coerce[d] . . . into adopting estate or inheritance tax laws" by a similarly structured federal tax with an 80 percent credit).

And the courts have uniformly rejected claims of coercion based on the federal grant's importance to critical state services, including health care. *California*, 104 F.3d at 1092 (no coercion where state claimed "no choice" but to accept Medicaid grant "to prevent a collapse of its medical system"); *Oklahoma*, 655 F.2d at at 413 (no coercion although "loss of Medicaid funds" would be "drastic"); *Van Wyhe*, 581 F.3d at 652 (no coercion even though loss of prison funding "would indeed be painful"); *see also Kansas*, 214 F.3d at 1202 (noting consensus that Medicaid grants are not coercive, "even where the removal of Medicaid funding would devastate the state's medical system").[13]

Moreover, any claim of coercion is particularly misplaced where, as here, the conditions being challenged define the terms of eligibility for the very program Congress is funding, rather than conditioning funding on the acceptance of subsidiary requirements. *Cf. Dole*, 483 U.S. at 208-09 (conditioning grant of federal highway funds on establishment of minimum drinking age); *id.* at 215 (O'Connor, J., dissenting) (describing that condition as "tangential" to the federal interest). Indeed,

[13] Plaintiffs fare no better under the Fourth Circuit's approach to the coercion theory. As this Court has recognized, the Fourth Circuit stands alone in resisting the prevailing view that the coercion theory is moribund. Slip op. at 55. But that court also has never invalidated a spending condition under the theory. *See West Virginia*, 289 F.3d at 291-94 (holding that "the mere possibility" that a State could lose all of its Medicaid funds does not establish unconstitutional coercion given that the Secretary has discretion under the Medicaid Act, 42 U.S.C. § 1396c, to withhold only part of a State's Medicaid funds). In any event, that court has indicated that a coercion claim might lie, if at all, where the federal government "'withholds the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some *insubstantial* respect.'" *Id.* at 293 (quoting dictum from *Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (en banc) (opinion of Luttig, J.) (emphasis added), which invalidated a spending condition on other grounds). Even if that were the correct test, it would have no application here, where the challenged condition is far from "insubstantial." The mandatory coverage of groups that Congress has designated as "categorically needy" is and always has been *the* core requirement of Medicaid.

plaintiffs concede that prior Medicaid amendments "mainly addressed eligibility criteria to provide better and more extensive coverage for the needy" and thus "were within the original and foreseeable spirit of the Medicaid partnership." Pls.' Opp'n to Defs.' Mot. Dism. 46. But the ACA's amendments to Medicaid likewise expand eligibility and coverage. Plaintiffs offer no reason why Congress could constitutionally expand Medicaid to recipients of Supplemental Security Income in 1972, and to pregnant women and children in 1989, *see* Pub. L. No. 92-603 (1972); Pub. L. No. 101-239 (1989), but cannot constitutionally expand it to low-income adults without dependent children here.

If plaintiffs were correct that the size or importance of federal Medicaid grants renders them coercive, then *any* amendments to Medicaid, no matter how big or small, would likewise be coercive. Medicaid would be frozen in time. And States would be able to dictate how Congress designs federal programs — indeed, to coerce the federal government into providing funds only on the terms favored by each State. To so hold would turn the Spending Clause on its head.

CONCLUSION

For the foregoing reasons, the Court should enter judgment in favor of Defendants on Counts One and Four of the Amended Complaint.

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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.

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