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In the Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF STATE PETITIONERS ON MEDICAID

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
BLAINE H. WINSHIP
Office of the Attorney General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

January 10, 2012 *(Additional Counsel Listed on Inside Cover)*

GREG ABBOTT
Attorney General of Texas
BILL COBB
Deputy Attorney General for Civil Litigation
Office of the Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

JON BRUNING
Attorney General of Nebraska
KATHERINE J. SPOHN
Special Counsel to the Attorney General
Office of the Attorney General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

ALAN WILSON
Attorney General of South Carolina
P.O. Box 11549
Columbia, SC 29211

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

LUTHER STRANGE
Attorney General of Alabama
501 Washington Avenue
Montgomery, AL 36130

JAMES D. "BUDDY" CALDWELL
Attorney General of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

BILL SCHUETTE
Attorney General of Michigan
P.O. Box 30212
Lansing, MI 48909

JOHN W. SUTHERS
Attorney General of Colorado
1525 Sherman Street,
Denver, CO 80203

ROBERT M. MCKENNA
Attorney General of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
DAVID B. RIVKIN
LEE A. CASEY
Baker & Hostetler LLP
Special Counsel
30 East Broad Street
17th Floor
Columbus, OH 43215

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, AZ 85007

WAYNE STENEJHEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

RICHARD SVOBODNY
Acting Attorney General
of Alaska
P.O. Box 110300
Juneau, AK 99811

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

QUESTION PRESENTED

Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress' spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

PARTIES TO THE PROCEEDINGS

Petitioners, who were the appellees/cross-appellants below, are 26 States: Florida, by and through Attorney General Pam Bondi; South Carolina, by and through Attorney General Alan Wilson; Nebraska, by and through Attorney General Jon Bruning; Texas, by and through Attorney General Greg Abbott; Utah, by and through Attorney General Mark L. Shurtleff; Louisiana, by and through Attorney General James D. "Buddy" Caldwell; Alabama, by and through Attorney General Luther Strange; Attorney General Bill Schuette, on behalf of the People of Michigan; Colorado, by and through Attorney General John W. Suthers; Pennsylvania, by and through Governor Thomas W. Corbett, Jr., and Attorney General Linda L. Kelly; Washington, by and through Attorney General Robert M. McKenna; Idaho, by and through Attorney General Lawrence G. Wasden; South Dakota, by and through Attorney General Marty J. Jackley; Indiana, by and through Attorney General Gregory F. Zoeller; North Dakota, by and through Attorney General Wayne Stenehjem; Mississippi, by and through Governor Haley Barbour; Arizona, by and through Governor Janice K. Brewer and Attorney General Thomas C. Horne; Nevada, by and through Governor Brian Sandoval; Georgia, by and through Attorney General Samuel S. Olens; Alaska, by and through Acting Attorney General Richard Svobodny; Ohio, by and through Attorney General Michael DeWine; Kansas, by and through Attorney General Derek Schmidt; Wyoming, by and through Governor Matthew H. Mead; Wisconsin, by and through Attorney General J.B. Van Hollen; Maine,

by and through Attorney General William J. Schneider; and Governor Terry E. Branstad, on behalf of the People of Iowa.

Respondents, who were the appellants/cross-appellees below, are the U.S. Department of Health & Human Services; Kathleen Sebelius, Secretary, U.S. Department of Health & Human Services; the U.S. Department of Treasury; Timothy F. Geithner, Secretary, U.S. Department of Treasury; the U.S. Department of Labor; and Hilda L. Solis, Secretary, U.S. Department of Labor.

TABLE OF CONTENTS

QUESTION PRESENTED i
PARTIES TO THE PROCEEDING.......................... ii
TABLE OF AUTHORITIES vi
OPINIONS BELOW..1
JURISDICTION..1
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED....................................1
STATEMENT OF THE CASE..................................2
A. Statutory Background.................................2
1. The Medicaid Program............................2
2. The ACA's Expansion of Medicaid..........6
B. District Court Proceedings........................13
C. The Eleventh Circuit's Decision................19
SUMMARY OF ARGUMENT.................................20
ARGUMENT 24
I. The Court Should Reaffirm The Vital Constitutional Limitaton That Congress May Not Use Its Spending Power Coercively 24
II. The ACA's Amendments To Medicaid Are Unconstitutionally Coercive. 32
A. The ACA Is Premised on the Understanding that It Forces States to Expand Medicaid. 33
B. The ACA's Coerciveness Is Confirmed By Medicaid's Sheer Size and

Congress' Attachment of New Terms to Pre-existing Funding. 39

C. States Have No Realistic Alternative to Continued Participation in Medicaid. 42

D. This Court's Precedents Support the Conclusion that the ACA Is Coercive. 48

III. Holding the ACA Unconstitutionally Coercive Will Not Lead To Wholesale Invalidation of Spending Legislation. 53

CONCLUSION 60

STATUTORY APPENDIX

U.S. Const., art. I, § 8, cl. 1 .... 1a

U.S. Const., amend. X 2a

Relevant Provisions of the Patient Protection & Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care & Education Reconciliation Act of 2010, Pub. L. No. 111-152

Sec. 1501 .... 3a

Sec. 2001 .... 21a

Sec. 2002 .... 37a

Sec. 2304 .... 45a

TABLE OF AUTHORITIES

Cases

Alaska Airlines, Inc. v. Brock,
480 U.S. 678 (1987)...55

Alexander v. Choate,
469 U.S. 287 (1985).. 5

Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy,
548 U.S. 291 (2006).. 27

Barnes v. Gorman,
536 U.S. 181 (2002).. 27

Bond v. United States,
131 S. Ct. 2355 (2011).................................. 24, 25

Bowen v. Pub. Agencies Opposed to Soc. Sec. Entrapment,
477 U.S. 41 (1986).. 42

City of Boerne v. Flores,
521 U.S. 507.. 30

Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.,
527 U.S. 666 (1999)................................ 27, 32, 38

Davis v. Monroe Cnty. Bd. of Educ.,
526 U.S. 629 (1999).. 29

Frost & Frost Trucking Co. v. R.R. Comm'n,
271 U.S. 583 (1926).. 32

Garcia v. San Antonio Metro. Transit Auth.,
469 U.S. 528 (1985)................................ 24, 31, 54

Gibbons v. Ogden,
22 U.S. 1 (1824).. 28

Gregory v. Ashcroft,
501 U.S. 452 (1991).. 26

Harris v. McRae,
448 U.S. 297 (1980)... 4, 58

Hodel v. Va. Surface Mining & Reclamation Ass'n, Inc., 452 U.S. 264 (1981).................... 21, 51

Jim C. v. United States,
235 F.3d 1079 (8th Cir. 2000)..............................43

Madison v. Virginia,
474 F.3d 118 (4th Cir. 2006)......................... 46, 58

Marbury v. Madison,
5 U.S. 137 (1803).. 28

McCulloch v. Maryland,
17 U.S. 316 (1819).. 28, 31

New York v. United States,
505 U.S. 144 (1992).....................................*passim*

Oklahoma v. Schweiker,
655 F.2d 401 (D.C. Cir. 1981)............................. 45

Pennhurst State Sch. & Hosp. v. Halderman,
451 U.S. 1 (1981)..........................26, 27, 41, 45, 58

Printz v. United States,
521 U.S. 898 (1997)....................................... 25, 47

Sabri v. United States,
541 U.S. 600 (2004).. 27

Schweiker v. Gray Panthers,
453 U.S. 34 (1981)... 4, 37

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

Steward Machine Co. v. Davis, 301 U.S. 548 (1937) .... *passim*

Texas v. White, 74 U.S. 700 (1868) 25

United States v. Butler, 297 U.S. 1 (1936) .... *passim*

United States v. Lopez, 514 U.S. 549 (1995) .... *passim*

United States v. Morrison, 529 U.S. 598 (2000) 31

Va. Dep't of Educ. v. Riley, 106 F.3d 559 (4th Cir. 1997) 43

Constitutional Provisions

U.S. Const., art. I, § 8, cl. 1 (General Welfare Cl.) 1

U.S. Const., amend. X 1, 29

Statutes

26 U.S.C.A. § 5000A(f)(1)(A)(ii) 12, 34

28 U.S.C. § 1254(1) 1

42 U.S.C. § 1304 .... 20, 42

42 U.S.C. § 1396 2

42 U.S.C. § 1396a(a)(10) (1970) 2

42 U.S.C. § 1396b(a) 16

42 U.S.C. § 1396c 20, 36

42 U.S.C. § 1396d(b) 15

42 U.S.C. § 602(a)(3) 11

American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, § 5001(f) 6

Consolidated Omnibus Budget Reconcilation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, § 9501 5

Deficit Reduction Act of 1984, Pub. L. No. 96-369, 98 Stat, 494, § 2361 5

Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874, § 9401(b) 6

Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, § 6401 5

Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388, § 4501 5

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (ACA) .... *passim*

ACA § 1331(a) 13

ACA § 1331(e)(1) 13

ACA § 1321(c) 12

ACA § 1401(a) 12, 36

ACA § 1413(a) 12

ACA § 1501 16

ACA § 1501(a)(1)(D) 6, 54

ACA § 1501(b) 8, 12, 34

ACA § 2001(a)..7

ACA § 2001(a)(2) 8

ACA § 2001(a)(3) 8

ACA § 2001(b)..9, 45

ACA § 2002(a)..7

ACA § 2304 9

Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat, 1329 ....3, 4

Social Security Act of 1965, Title XIX, 42 U.S.C. § 1396 *et seq*...2

Other Authorities

Cong. Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010) 9, 16

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Cong. Budget Office, *The Long-Term Budget Outlook* (June 2010)...18

Fed'n of Tax Adm'rs., *2009 State Tax Revenue*........44

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Letter from Douglas Elmendorf, Director, CBO, to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps. (Mar. 20, 2010) ... 9, 10, 16, 55

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S. Rep. No. 93-553 (1973) 4

U.S. Census Bureau, *Federal Aid to States for Fiscal Year 2009* (August 2010) 56

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OPINIONS BELOW

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JURISDICTION

The Eleventh Circuit rendered its decision on August 12, 2011. The States filed a timely petition for certiorari, and this Court granted review of the first question presented on November 14, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The General Welfare Clause and the Tenth Amendment to the U.S. Constitution, and the relevant provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, the "ACA" or "Act"), are reproduced in an appendix to this brief.[2]

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[1] For ease of reference, all citations of the Petition Appendix in all briefs arising out of the decision below are of the appendix to the federal government's petition for certiorari in *U.S. Department of Health and Human Services v. Florida*, No. 11-398. Citations of the Eleventh Circuit Record Excerpts are designated "R.E."

[2] All citations of provisions of the "ACA" are of the Affordable Care Act as amended by the Reconciliation Act.

STATEMENT OF THE CASE

A. Statutory Background

1. The Medicaid Program

Congress established Medicaid in 1965. *See* Social Security Act of 1965, Title XIX, codified at 42 U.S.C. § 1396 *et seq.* At its inception, Medicaid was structured as a cooperative federal-state partnership: States that funded certain types of medical assistance for specific categories of needy residents were provided federal reimbursement for at least 50% and as much as 83% of the cost of that assistance.

An individual's eligibility to participate in Medicaid originally piggy-backed on eligibility for one of four public aid programs: Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. *See* 42 U.S.C. § 1396a(a)(10) (1970). Like Medicaid itself, each of those programs was a state-run cooperative endeavor with the federal government, meaning each left States with significant control over eligibility for participation. Thus, while the Medicaid program as originally conceived required participating States to provide medical assistance to certain categories of individuals—needy families with dependent children, the elderly, the blind, and the disabled—within those categories, States retained real discretion in setting threshold eligibility criteria in accordance with their own budgetary constraints. Moreover, Congress gave States a true choice about whether and how to participate: States' participation in the four other partnerships did not

necessitate participation in Medicaid; nor was their discretion in determining eligibility for those programs limited by their acceptance of Medicaid funding.

In its first year, Medicaid covered approximately 4 million individuals and cost about $1 billion nationwide. John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Financing Review 105 (Fall 2000) ("Klemm Report").[3] The program's voluntary nature was underscored by the fact that not all States initially decided to participate. The program gradually expanded as more States opted in, and by 1971 it covered approximately 16 million individuals and cost about $6.5 billion. Klemm Report 106.

The first significant alteration to the basic criteria for participation in Medicaid came in 1972, when Congress established Supplemental Security Income for the Aged, Blind, and Disabled ("SSI"). *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, § 301 ("1972 SSA Act"). In doing so, Congress created a single federally administered program that replaced the earlier state-run public aid programs that had, in turn, established Medicaid eligibility for those three categorically needy groups. While Congress left intact Aid to Families with Dependent Children, as well as the States' discretion to determine eligibility for that program, it eliminated the States' role in setting eligibility thresholds for the aged, blind, and

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[3] Available at http://www.nd.edu/~dbetson/courses/documents /BriefHistoryofSpending.pdf.

disabled individuals previously served by the other three programs. As a result, "[i]n some States the number of individuals eligible for SSI assistance was significantly larger than the number eligible under the earlier, state-run categorical need programs." *Schweiker v. Gray Panthers*, 453 U.S. 34, 38 (1981).

Congress considered conditioning each State's continued participation in Medicaid on the State's willingness to extend coverage to all individuals made eligible for SSI aid, but it "feared that these States would withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage in a manner commensurate with the expansion of categorical assistance." *Id.* Accordingly, Congress chose not to strong arm States but to accommodate them, offering participating States the option of either expanding coverage to all SSI-eligible individuals (with a corresponding increase in federal funding), or maintaining Medicaid coverage for only those individuals eligible under the State's most recent Medicaid plan. *See id.* at 38–39 & nn.3–6; 1972 SSA Act § 209(b); S. Rep. No. 93-553, at 56 (1973) (noting that Congress created § 209(b) option "in order not to impose a substantial fiscal burden on these States").

As States continued to expand eligibility and coverage, by 1980, Medicaid had grown to a $26 billion program covering more than 20 million individuals, Klemm Report 106–08, leading this Court to recognize that "a complete withdrawal of the federal prop in the system … could seriously cripple a state's attempts to provide other necessary medical services" to its residents. *Harris v. McRae*,

448 U.S. 297, 309 n.12 (1980) (internal quotation marks omitted).

By 1982, every State was participating, to some extent, in Medicaid. Around the same time, Congress began gradually adding separate eligibility requirements for two new groups: children and pregnant women. Although whether to expand coverage to those two groups was initially left to each State's discretion, Congress eventually demanded coverage for those groups as a criterion for continued participation in Medicaid.[4] By the end of the decade, Congress mandated coverage for all pregnant women, children age 5 and under with family incomes below 133% of the federal poverty level, and children between the ages of 6 and 18 with family incomes below the federal poverty level.[5]

Throughout Medicaid's history, Congress has consistently "give[n] the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (quoting 42 U.S.C. § 1396a(a)(19)). And while Congress periodically increased eligibility thresholds

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[4] *See, e.g.*, Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, § 2361 (extending coverage to children under age 5 and first-time pregnant women financially eligible for public aid); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, § 9501 (extending coverage to all pregnant women financially eligible for public aid).

[5] *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, 103 Stat. 2106, § 6401; Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388, § 4601.

for certain categories of needy, at no time did Congress establish mandatory coverage criteria for childless adults who are not within the covered categories. Although many States have extended coverage to such individuals voluntarily, whether and to what extent to do so had always remained the prerogative of the States. Congress at times sought to encourage States to retain various existing voluntary expansions of coverage through so-called "maintenance-of-effort" provisions, but those provisions, like the provisions allowing States voluntarily to expand coverage in the first place, have traditionally been incentive-based: Rather than compel States to maintain voluntary expansions, Congress typically offered additional funding to States that agreed to do so.[6]

2. The ACA's Expansion of Medicaid

The ACA is a 2,700-page collection of sweeping provisions intended to impose "near-universal" health insurance coverage on the Nation. ACA § 1501(a)(1)(D). The Act attempts to achieve that goal by increasing both the demand for and the supply of insurance. On the demand side, the Act's individual mandate requires nearly every individual to obtain a minimum level of health insurance

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[6] *See, e.g.*, Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874, § 9401(b) (offering additional funding to States that agreed to expand eligibility, but only if they also maintained existing payment levels); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, § 5001(f) (offering additional funding to States that agreed to maintain eligibility standards in effect on July 1, 2008).

coverage. On the supply side, the Act has a set of core components designed to expand the availability of private and public insurance to satisfy the demand forcibly created by the individual mandate. Each of those components targets a distinct segment of the previously uninsured population. The principal means by which Congress sought to ensure coverage for low-income individuals is through a dramatic transformation of Medicaid, scheduled to take effect in 2014 along with the individual mandate.

Title II of the ACA expands the Medicaid program in multiple respects and transforms it from a cooperative program addressed to specific categories of the most needy into a mandatory program designed to fulfill the individual mandate for the entire non-elderly population with income below 138% of the federal poverty line. Whereas States traditionally were required to offer Medicaid only to those low-income individuals who fell within certain "categorically needy" groups (families with dependent children, elderly, blind, disabled, children, and pregnant women), and retained significant flexibility to determine whether and to what extent to cover other low-income individuals, the Act requires States to cover *all* individuals under age 65 with incomes up to 133% of the poverty level, with a 5% "income disregard" provision that effectively raises that threshold to 138%. ACA §§ 2001(a), 2002(a).

By mandating coverage of millions more individuals, including "childless adults who have historically been ineligible for the program," the Act will "necessitat[e] one of the largest enrollment

efforts in the program's history." Kaiser Comm'n on Medicaid & the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform* 1 (July 2010).[7] Equally important, by tying Medicaid to the near-universal individual mandate and requiring Medicaid coverage for everyone below 138% of the poverty level, the ACA transforms the basic nature of the program. Although the federal government will initially fund 100% of that expansion, by 2017, States will be responsible for 5% of those costs, with that number increasing to 10% by the end of the decade. ACA § 2001(a)(3).

As a reflection of the close connection between the individual mandate and the Medicaid expansion, the ACA also establishes a new "minimum essential coverage" level—a level sufficient to satisfy a recipient's obligations under the individual mandate—that States must provide to all Medicaid recipients. *Id.* §§ 2001(a)(2), 1501(b). That new and onerous requirement eliminates the flexibility States previously enjoyed to determine what level of coverage they could afford to offer to the diverse groups of individuals they chose to cover.

In the shorter term, the Act also locks States into their current eligibility and coverage rates—even those that exceed federal requirements and were voluntary when adopted—through its maintenance-of-effort provision that takes effect immediately (rather than in 2014). Unlike many prior maintenance-of-effort provisions, *see supra*, p. 6 & n.6, the ACA's provision renders maintenance of

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[7] Available at http://www.kff.org/medicaid/upload/8087.pdf.

all "eligibility standards, methodologies, or procedures" currently in place "a condition for receiving *any* Federal payments" until the State has complied with other aspects of the ACA. *Id.* § 2001(b) (emphasis added). As a result, the provision effectively forces States to maintain their current Medicaid spending levels until the massive expansion takes effect in 2014, thereby precluding States from cutting costs now in preparation for the impending spending increase that the expansion will require. In doing so, the provision both eliminates States' traditional discretion to set eligibility thresholds and coverage rates, and essentially penalizes States for having voluntarily extended more generous coverage than Congress required.

Finally, the Act requires States not only to pay the costs of care and services for Medicaid enrollees, but also to assume responsibility for providing "the care and services themselves." ACA § 2304. That provision effectively exposes States to liability if the demand for services is greater than the supply of hospitals and doctors willing to provide them.

In conjunction with the individual mandate, the federal government predicts that the Medicaid expansion will increase enrollment by approximately 16 million by the end of the decade. Letter from Douglas Elmendorf, Director, Cong. Budget Office (CBO), to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps. ("CBO Estimate") 9 (Mar. 20, 2010); *see also* CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010) (estimating that 6–7 million of those individuals

would not enroll in Medicaid without the mandate).[8] To finance that massive expansion, the federal government anticipates that its share of Medicaid spending will increase by $434 billion by 2020. CBO Estimate, Table 4 (Mar. 20, 2010). It further estimates that state spending will increase by at least $20 billion over the same timeframe. CBO Estimate, Table 4 n.c (Mar. 20, 2010). Other estimates suggest that both federal and state costs will be significantly higher. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* 23 (May 2010) (estimating that increased costs could be as high as $532 billion for federal government and $43.2 billion for States).[9]

Unlike in many of its early amendments to Medicaid, Congress did not separate the new coverage requirements and the new funding from the rest of the program and give States the option of continuing to participate in Medicaid while declining to undertake the expansion. If it had, States could have meaningfully assessed whether the newly available funds justified undertaking the onerous new obligations that the Act envisions. Congress instead made the new terms a condition of continued participation in Medicaid, thereby threatening each

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[8] Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf; and http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

[9] Available at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

State with the loss of *all* federal Medicaid funds—for most States, more than a billion dollars per year—unless it adopts the Act's substantial expansion of state obligations under the program.

Indeed, it is worse than that, as the expectation that States will continue to participate in Medicaid is built into requirements for other federal spending programs as well, meaning a State may stand to lose even more than just Medicaid funding if it refuses to accept the ACA's conditions for continued participation. *See, e.g.*, 42 U.S.C. § 602(a)(3) (requiring, as condition of receipt of Temporary Assistance for Needy Families funding, that a State "operate a foster care and adoption assistance program" and ensure that children served by the program "are eligible for medical assistance under the State['s Medicaid] plan"); JA 87 ¶ 12 (declaration from Florida attesting that opting out of Medicaid might jeopardize more than $562 million in annual TANF funding).

While the ACA purports to leave States' participation in Medicaid nominally voluntary, multiple aspects of the Act evince Congress' keen awareness that, in fact, no State will be able to reject its new terms and withdraw from the program. Most obviously, the ACA's individual mandate requires Medicaid-eligible individuals to obtain and maintain insurance. The mandate, like the Medicaid expansion, takes effect in 2014. The Act expressly renders enrollment in Medicaid a means of complying with the individual mandate, but provides no alternative mechanism through which the neediest of individuals might obtain insurance in a State that declined to participate in the newly

expanded Medicaid program. *See* ACA § 1501(b), 26 U.S.C.A. § 5000A(f)(1)(A)(ii). The contrast with other components of the ACA is telling. For example, the ACA's "health benefit exchange" provisions, which offer substantial new funding to States willing to implement such exchanges, expressly provide that the federal government will create and operate an exchange if a State declines the federal funding. ACA § 1321(c).

In addition, while the ACA creates significant subsidies for low-income individuals who purchase insurance on the exchanges, those credits and options are available only to those whose income exceeds the federal poverty level, meaning the majority of individuals that Congress presumed would be eligible for Medicaid could not take advantage of the federal subsidies. *See* ACA § 1401(a) (adding § 36B(c)(1)(A) to subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code (IRC) of 1986). Indeed, if an individual applying for insurance through an exchange is eligible for coverage under a State's Medicaid plan, the individual automatically will be enrolled in Medicaid instead, meaning Congress did not envision the exchanges being available to any Medicaid-eligible individuals. ACA § 1413(a). The Act underscores the necessary role that Medicaid plays in determining who is eligible for the new subsidies by including an exception for taxpayers whose income is below the poverty-level eligibility threshold if "the taxpayer is an alien lawfully present in the United States, *but is not eligible for the medicaid program* … by reason of such alien status." ACA § 1401(a) (adding § 36B(c)(1)(B);

emphasis added). There is no comparable exception for individuals below the threshold who reside in States that decline to participate in Medicaid.

Relatedly, in a provision entitled "State Flexibility to Establish Basic Health Programs for Low-Income Individuals *Not Eligible for Medicaid*," the Act gives States the option of offering approved "standard health plans" to low-income individuals "in lieu of offering such individuals coverage through an Exchange." ACA § 1331(a). But Congress only allows States to offer those plans to individuals under age 65 whose income level exceeds 133% of the poverty level, which are the same qualifications that the ACA establishes for Medicaid eligibility. ACA § 1331(e)(1). Once again, there is an exception for lawful aliens "not eligible for the Medicaid program," but no provision for an individual residing in a State that declines to participate in Medicaid. *Id.*

B. The District Court Proceedings

1. Shortly after Congress passed the ACA, Florida and 12 other States brought this action seeking a declaratory judgment that the Act is unconstitutional. They were subsequently joined by 13 additional States. The States challenged a number of the Act's provisions, including the ACA's expansion of Medicaid on the ground that it is unconstitutionally coercive.

The federal government moved to dismiss the States' challenge, arguing that an offer of federal funding to States under Congress' spending power can never be unconstitutionally coercive. The District Court denied the motion, concluding that, "[i]f the Supreme Court meant what it said in *Dole*

and *Steward Machine* …, there is a line somewhere between mere pressure and impermissible coercion." Pet. App. 463a. Observing that the coerciveness of the ACA "can perhaps be inferred from the fact that Congress does not really anticipate that the states will (or could) drop out of the Medicaid program," Pet. App. 462a, the court concluded that the ACA's requirement that States significantly expand their obligations under Medicaid as a condition of continued receipt of *any* federal Medicaid funding arguably fell on the impermissibly coercive side of that line. Pet. App. 462a–63a.

2. The parties filed cross-motions for summary judgment, and the States provided substantial unrebutted evidence that the ACA coerces them into expanding their Medicaid programs.

As the largely uncontested facts demonstrate, through a combination of mandatory and voluntary expansions of eligibility and coverage, as well as demographic and economic changes over the past half-century, Medicaid has grown exponentially and is now the single largest federal grant-in-aid program to the States. Medicaid presently accounts for more than 40% of all federal funds dispersed to States and approximately 7% of all federal spending. In 2009 alone, States received more than $250 billion in federal Medicaid spending, with most States receiving at least $1 billion, and nearly a third of States receiving more than $5 billion. Henry J. Kaiser Found., *Federal & State Share of Medicaid*

Spending, FY2009 ("*Medicaid Spending, FY2009*").[10] Federal funding continues to cover no less than 50% and as much as 83% of each State's Medicaid costs, 42 U.S.C. § 1396d(b), and, for the average State, combined state and federal Medicaid spending are the equivalent of approximately 20% of the State's *total* annual budget outlays. Nat'l Ass'n of State Budget Officers, *2008 State Expenditure Report* ("NASBO Report"), Table 5 (*State Spending by Function as a Percent of Total State Expenditures, Fiscal 2008*) (Fall 2009).[11] Moreover, all of those numbers reflect federal and state spending *before* the significant increases envisioned by the ACA.

For example, Florida estimated that, in 2010, providing the same coverage that it provides under Medicaid pre-ACA would cost at least $20 billion and would account for 28% of the State's total annual budget. JA 72 ¶8. Florida estimated that the federal government would cover approximately $13 billion of those costs. Paying for Medicaid without any federal contribution would consume nearly two thirds of Florida's $32 billion in annual tax collections. And the prospect of simply raising taxes to cover the additional costs is not a real one, as the federal government already collects more than *$100 billion* in taxes from Florida's residents. Mem. Supp. Pltfs.' Mot. Summ. J. 33 [R.E. 493].

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[10] Available at http://www.statehealthfacts.org/comparemaptable.jsp?ind=636&cat=4.

[11] Available at http://www.nasbo.org/LinkClick.aspx?fileticket=%2FZWfTvJG8j0%3D&tabid=107&mid=570.

The States also explained why they would not voluntarily accept the ACA's new terms if given a choice. The federal government's own evidence demonstrates that the expansion is expected to cost States at least $20 billion by the end of the decade, *see* CBO Estimate, Table 4 (March 20, 2010), and other estimates are more than double. *See* Kaiser Comm'n, *Medicaid Coverage & Spending*, 23 (estimating that increased costs could be as high as $43.2 billion for States). As the States explained, the significant increase in state spending is to some extent a product of the mandated eligibility expansion, which States will begin to fund in part in 2017. But there are numerous other anticipated costs, including the massive administrative costs of implementing the new federal program,[12] and substantial costs generated by individuals who are presently eligible for but not enrolled in Medicaid, as such individuals will now be forced to enroll in order to comply with the ACA's individual mandate provision, ACA § 1501. *See* CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 12 (Dec. 2008) (estimating that, in 2009, 18% of uninsured were eligible for but not enrolled in Medicaid)[13]; *cf.* CBO Report (June 16, 2010) (estimating that 6–7 million fewer individuals would enroll in Medicaid without the mandate).

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[12] The federal government typically pays only 50% of each State's administrative costs. *See* 42 U.S.C. § 1396b(a)(2)–(5), (7).

[13] Available at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

Florida estimates that, as a result of the ACA, its share of Medicaid spending will increase by $1 billion annually by the end of the decade. JA 76 ¶ 15. Florida anticipates spending approximately $351 million on its share of the cost for newly eligible program participants who are presently uninsured and $574 million on the currently eligible but unenrolled. JA 76 ¶¶ 17–18. The considerable cost for the latter reflects the fact that, unlike for the newly eligible, Congress has not increased federal funding for those newly enrolled (but previously eligible) by virtue of the ACA's individual mandate. As a result, the States will continue to pay for up to half of the costs generated by the latter group's now-mandatory enrollment. Florida also anticipates spending tens of millions on administrative costs, children who are currently covered by the Children's Health Insurance Program but will shift to Medicaid, and individuals who are presently insured privately but will switch to Medicaid once they become eligible under the ACA's expanded criteria. JA 77 ¶ 20.

Numerous States provided evidence that their situations are equally bleak. *See, e.g.*, JA 116 ¶ 5 (Arizona anticipates additional spending of between $7.5 and $11.6 billion over ten years); JA 125 ¶ 13 (Indiana anticipates additional spending of between $2.6 to $3.1 billion over ten years); JA 135 ¶ 4 (Louisiana anticipates additional spending of approximately $7 billion over ten years); JA 192 (Texas anticipates additional annual spending of $1 billion in 2014–16, $2.1 billion in 2017–19, and $4.4 billion annually thereafter).

Indeed, Medicaid spending has become such a drain on the States that, at the same time that Congress is mandating a significant *increase* in state Medicaid spending, the federal government has recognized that the fiscal stability of States over the next decade will depend largely on their ability to *reduce* the seemingly ever-increasing costs of the program. *See* CBO, *The Long-Term Budget Outlook* 27 (June 2010) ("state governments—which pay a large share of Medicaid's costs and have considerable influence on those costs—will need to reduce spending growth in order to balance their budgets"); U.S. Gov't Accountability Office, *State and Local Governments: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs* (GAO-10-899) 6 (July 2010) (recommending States immediately and persistently cut Medicaid and other costs "for each and every year going forward equivalent to a 12.3 percent reduction in state and local government current expenditures").[14]

3. Notwithstanding the States' compelling evidence that the ACA leaves them with no choice but to continue to participate in Medicaid under the Act's significantly more onerous conditions, the District Court granted summary judgment to the federal government on the States' coercion claim. Pet. App. 288a. Despite having previously acknowledged that *South Dakota v. Dole*, 483 U.S. 203 (1987), and *Steward Machine Co. v. Davis*, 301

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[14] Available at http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf and http://www.gao.gov/new.items/d10899.pdf.

U.S. 548 (1937), recognize a line between pressure and coercion, the court deemed existing precedent insufficient to support invalidation of spending legislation as unconstitutionally coercive. Pet. App. 287a. Although the court acknowledged "the difficult situation in which the states find themselves," it concluded that "unless and until" this Court "revisit[s] and reconsider[s] its Spending Clause cases," "the states have little recourse to remaining the very junior partner in th[e state-federal] partnership." Pet. App. 287a–88a.

C. The Eleventh Circuit's Decision

The Eleventh Circuit affirmed the District Court's rejection of the States' challenge to the Medicaid expansion. Pet. App. 3a. "[N]ot without serious thought and some hesitation," the court concluded that the States failed to establish coercion. Pet. App. 60a. The court recognized that "many circuits [have] conclu[ded] that the [coercion] doctrine, twice recognized by the Supreme Court, is not a viable defense to Spending Clause legislation." Pet. App. 56a–57a. But it concluded that "[t]o say that the coercion doctrine is not viable or does not exist is to ignore Supreme Court precedent." Pet. App. 59a. It further noted, "[i]f the government is correct that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it." Pet. App. 59a–60a.

Nonetheless, the court rejected the States' coercion claim, offering five factors that it considered "determinative": (1) "Congress reserved the right to make changes to the [Medicaid] program" in 42

U.S.C. § 1304; (2) "the federal government will bear nearly all of the costs associated with the expansion"; (3) "states have plenty of notice … to decide whether they will continue to participate in Medicaid" before the expansion takes effect in 2014; (4) "states have the power to tax and raise revenue and therefore can create and fund programs of their own if they do not like Congress's terms"; and (5) the Secretary of Health and Human Services has "discretion to withhold all or merely a portion of funding from a noncompliant state" under 42 U.S.C. § 1396c. Pet. App. 60a–62a. The court deemed those factors, "[t]aken together," sufficient to demonstrate that "states have a real choice" whether to continue participating in Medicaid. Pet. App. 63a.

SUMMARY OF ARGUMENT

For the better part of a century, this Court has recognized that the spending power is not "the instrument for total subversion of the governmental powers reserved to the individual states." *United States v. Butler*, 297 U.S. 1, 75 (1936). It could hardly be otherwise. Congress self-evidently could not impose the enormous burdens on the States envisioned by the ACA through direct compulsory legislation. Thus, absent a limit on Congress' ability to impose these same burdens through nominally voluntary exercises of the spending power, all other efforts to constrain Congress and preserve Our Federalism would be for naught. In other words, a judicially enforceable outer limit on Congress' power to use federal tax dollars to coerce States is not just consistent with this Court's precedent; it is a constitutional necessity. And if the ACA's expansion

of Medicaid does not surpass that limit, then no Act of Congress ever will.

The proposition that Congress may not use its spending power to coerce the States is a necessary consequence of the principle that "Congress may not simply 'commandee[r] the legislative processes of the States.'" *New York v. United States*, 505 U.S. 144, 161 (1992) (quoting *Hodel v. Va. Surface Mining & Reclamation Ass'n, Inc.*, 452 U.S. 264, 288 (1981)). The Court's renewed focus on the anti-commandeering principle only magnifies the importance of enforcing meaningful limits on the spending power. If Congress were free to use its spending power to coerce States into enforcing the federal government's dictates, then the spending power would become the exception that swallows the anti-commandeering rule.

The coercion doctrine is also an essential corollary of this Court's holding that Congress' spending power "is not limited by the direct grants of legislative power found in the Constitution." *Butler*, 297 U.S. at 66. If Congress could use its spending power only where it could legislate directly, then the rule against coercive uses of the spending power would be needed only to protect States against commandeering. But this Court's recognition of a broader spending power necessarily carries with it the obligation to ensure that Congress does not misuse its spending power to coerce States into bringing their police power to bear on subjects far outside Congress' limited and enumerated powers. For precisely those reasons, the Court has long recognized that a spending power without limits would be tantamount to a federal government

without limits, something the Court has never been willing to sanction.

Just as it is clear that there must be a judicially enforceable limit on Congress' spending power, it is equally clear that the ACA exceeds it. While difficult cases will surely arise about when persuasion crosses the line into coercion, this is not one of them. Congress itself recognized that the Medicaid expansion was not truly voluntary when it made that expansion critical to compliance with the individual mandate. Congress created a mandate for all individuals to obtain insurance while providing no alternative to Medicaid for the most needy to obtain the mandated insurance. Simply put, a program that is necessary for the satisfaction of a mandate is not voluntary. It is mandatory.

Congress did not provide an alternative for needy residents of States that opt out of Medicaid because Congress knew that no State could or would opt out. The ACA's contrary approach to two other issues is telling. Because States were given a meaningful choice whether to operate the health benefit exchanges created by the Act, there is a plan B. The federal government will step in if States decline. For Medicaid, there is no fallback. And because States need not provide Medicaid to lawfully present aliens, Congress extended subsidies to lawful aliens below the poverty level. There is no comparable provision for citizens residing in States that opt out of Medicaid, not because Congress was indifferent to whether such citizens were insured, but because Congress understood that it had not given States a real option.

Congress' assumption that States would have no choice but to accept its new terms is unconstitutional, but not unrealistic. The ACA threatens States with the loss of every penny of federal funding under the single largest grant-in-aid program in existence—literally *billions* of dollars each year—if they do not capitulate to Congress' steep new demands. There is no plausible argument that a State could afford to turn down such a massive federal inducement, particularly when doing so would mean assuming the full burden of covering its neediest residents' medical costs, even as billions of federal tax dollars extracted from the State's residents would continue to fill federal coffers to fund Medicaid in the other 49 States.

Because the ACA's expansion of Medicaid is such an extreme and unprecedented abuse of Congress' spending power, this Court can declare the Act's Medicaid provisions unconstitutional without jeopardizing spending legislation writ large. Indeed, there are multiple factors—including Congress' express linkage to an unprecedented mandate, Congress' manifest assumption that no State could or would opt out, the sheer size of the federal inducement at stake, Congress' refusal to limit the new conditions to new funds, and Congress' evident intent to coerce the States—that, taken together, put this coercion challenge in a class of its own. But if the Court were to hold the ACA constitutional in the face of that irrefutable evidence of coercion, the consequences to Our Federalism would be dire indeed. Such a decision would amount to a declaration that Congress' spending power is without bounds, meaning that the only thing

"stand[ing] between the remaining essentials of state sovereignty and Congress" would be "the latter's underdeveloped capacity for self-restraint." *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 588 (1985) (O'Connor, J., dissenting).

Congress easily could have designed an act that encouraged rather than forced States to expand their Medicaid programs, much as it did when creating the health benefit exchanges. By making a conscious decision to deprive States of any choice in the matter, Congress has effectively forced this Court's hand. "[T]he federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene when one or the other level of Government has tipped the scales too far." *United States v. Lopez*, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring). Because the challenged provisions cannot be upheld without admitting that inability, the Court should hold the Act's Medicaid expansion unconstitutional.

ARGUMENT

I. The Court Should Reaffirm The Vital Constitutional Limitation That Congress May Not Use Its Spending Power Coercively.

"Impermissible interference with state sovereignty is not within the enumerated powers of the National Government." *Bond v. United States*, 131 S. Ct. 2355, 2366 (2011). Accordingly, "[n]o matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate." *New*

York, 505 U.S. at 178; *see also Printz v. United States*, 521 U.S. 898, 925 (1997) ("[T]he Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs."). Just as Congress may not use its enumerated powers to commandeer the States directly, Congress may not abuse its spending power to coerce the same forbidden result. *See New York*, 505 U.S. at 166 ("Our cases have identified a variety of methods, *short of outright coercion*, by which Congress may urge a State to adopt a legislative program consistent with federal interests." (emphasis added)). Voluntariness is the key to avoiding commandeering: Under any "permissible method of encouraging a State to conform to federal policy choices, the residents of the State retain the ultimate decision as to whether or not the State will comply." *Id.* at 168.

That core limitation on Congress' power is a necessary reflection of the fact that "the preservation of the States, and the maintenance of their governments, are as much within the design and care of the Constitution as the preservation of the Union and the maintenance of the National government." *Texas v. White*, 74 U.S. 700, 725 (1868). Because "our federal system preserves the integrity, dignity, and residual sovereignty of the States," *Bond*, 131 S. Ct. at 2364, States must retain the ability to make meaningful choices about what policies to adopt and how to implement them. Only if States "remain independent and autonomous within their proper sphere of authority," *Printz*, 521 U.S. at 928, can "[f]ederalism secure[] the freedom of the individual." *Bond*, 131 S. Ct. at 2364; *see also*

Gregory v. Ashcroft, 501 U.S. 452, 459 (1991) ("In the tension between federal and state power lies the promise of liberty."). When Congress "issu[es] an unavoidable command" rather than "offer[ing] the States a legitimate choice," *New York*, 505 U.S. at 185, neither federalism nor liberty can thrive.

This Court has long recognized that limits on Congress' power to intrude on state sovereignty necessitate judicially enforceable limits on the spending power. "If, in lieu of compulsory regulation of subjects within the states' reserved jurisdiction, which is prohibited, the Congress could invoke the taxing and spending power as a means to accomplish the same end, clause 1 of section 8 of article 1 would become the instrument for total subversion of the governmental powers reserved to the individual states." *Butler*, 297 U.S. at 75. The Court's renewed insistence that Congress respect the integrity, dignity, and residual sovereignty of the States, including the prohibition on commandeering the States, only underscores the need for judicially enforceable limits on the spending power. If Congress remains free to go beyond voluntary initiatives of cooperative federalism to commandeer States by using the spending power to issue offers that cannot be refused, then anti-commandeering principles are merely parchment barriers.

To avoid that unacceptable result, the Court has imposed meaningful limits on Congress' exercise of its spending power, drawing from well-settled contract law principles. *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("[L]egislation enacted pursuant to the spending power is much in the nature of a contract.").

The constraint that Congress may not use its spending power coercively is both a constitutional necessity and a straightforward application of those principles. "Just as a valid contract requires offer and acceptance of its terms, '[t]he legitimacy of Congress' power to legislate under the spending power ... rests on whether the [recipient] *voluntarily* and knowingly accepts the terms of the 'contract.'" *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (quoting *Pennhurst*, 451 U.S. at 17; emphasis added); *see also Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (same). In other words, valid acceptance must be voluntary "not merely in theory but in fact." *Dole*, 483 U.S. at 211.

Because acceptance cannot be voluntary when the federal government abuses its powers (including the taxing power to raise revenue from residents of the States) to eliminate the element of choice, the Court has long recognized that an exercise of Congress' spending power would violate the Constitution if it were "so coercive as to pass the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590); *see also Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999); *Sabri v. United States*, 541 U.S. 600, 608 (2004). Nowhere is that more obvious than in legislation like the ACA that compels the States to act in ways that Congress could not compel directly. In that context, spending power legislation that crosses the line into compulsion self-evidently violates the Constitution.

It could hardly be otherwise. The coercion doctrine is as essential to preservation of the

Constitution's enumeration of limited federal powers as it is to the preservation of the integrity, dignity, and residual sovereignty of the States. From the earliest days of our Nation, the Court has recognized that "[t]he powers of the [federal] legislature are defined, and limited." *Marbury v. Madison*, 5 U.S. 137, 176 (1803); *see also McCulloch v. Maryland*, 17 U.S. 316, 405 (1819) ("The principle, that [Congress] can exercise only the powers granted to it … is now universally admitted."). That enumeration of limited powers "presupposes something not enumerated." *Gibbons v. Ogden*, 22 U.S. 1, 74 (1824). An unlimited spending power could not be reconciled with those fundamental principles.

Although the federal government will protest any effort to impose meaningful limits on the spending power, it has no basis to do so. Those limits are a necessary consequence of the federal government's successful effort to broaden the spending power. If the spending power were limited to spending on items within Congress' enumerated regulatory powers, then the Court would need to police only spending legislation that impermissibly commandeered the States or violated other affirmative limits on Congress' power. Yet this Court long ago accepted the federal government's invitation to view the spending power as not so limited. *See Butler*, 297 U.S. at 66; *Dole*, 483 U.S. at 207.

Thus, having accepted the federal government's invitation to view the spending power more broadly, it is incumbent on this Court to fashion judicially enforceable outer limits on the power that will ensure preservation of the federal balance and the

Constitution's broad reservation of powers to the States. *See* U.S. Const., amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."). Absent such enforceable limits, the spending power "has the potential to obliterate distinctions between national and local spheres of interest and power by permitting the Federal Government to set policy in the most sensitive areas of traditional state concern, areas which otherwise would lie outside its reach." *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 654–55 (1999) (Kennedy, J., dissenting).

Indeed, an unlimited spending power would be just as dangerous as a plenary regulatory authority and just as inconsistent with our Constitution's basic design. Without the limitation that Congress may not exercise its spending power coercively, Congress could use that power to compel the States to use their police power to reach any issue, no matter how far removed from Congress' limited and enumerated powers. The argument against recognizing a judicially enforceable distinction between coercion and persuasion therefore reduces to the untenable conclusion that, "though the makers of the Constitution, in erecting the federal government, intended sedulously to limit and define its powers, … they nevertheless by a single clause gave power to the Congress to" regulate all fields reserved to the States, "subject to no restrictions save such as are self-imposed." *Butler*, 297 U.S. at 78. "The argument, when seen in its true character and in the light of its inevitable results, must be rejected." *Id.*

That the line between coercion and persuasion may not be bright is no reason to abandon all efforts to police the line given its importance in preserving our constitutional balance. This Court is "often called upon to resolve questions of constitutional law not susceptible to the mechanical application of bright and clear lines," *Lopez*, 514 U.S. at 579 (Kennedy, J., concurring), particularly where conflicts between federal and state power arise. Notwithstanding the difficulty of resolving those weighty questions, the Court has not hesitated to do so to preserve the Constitution's essential structure. *See, e.g.*, *id.*; *City of Boerne v. Flores*, 521 U.S. 507, 519–20 (1997) ("While the line between measures that remedy or prevent unconstitutional actions and measures that make a substantive change in the governing law is not easy to discern … the distinction exists and must be observed."); *Butler*, 297 U.S. at 67 ("[D]espite the breadth of the legislative discretion [under the spending power], our duty to hear and to render judgment remains. If the statute plainly violates the stated principle of the Constitution we must so declare.").

Indeed, "the task of ascertaining the constitutional line between federal and state power has given rise to many of the Court's most difficult and celebrated cases." *New York*, 505 U.S. at 155. As the Court's consistent efforts to ascertain that line reflect, "the federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene when one or the other level of Government has tipped the scales too far." *Lopez*, 514 U.S. at 578 (Kennedy, J., concurring); *see*

also Garcia, 469 U.S. at 581 (O'Connor, J., dissenting) ("If federalism so conceived and so carefully cultivated by the Framers of our Constitution is to remain meaningful, this Court cannot abdicate its constitutional responsibility to oversee the Federal Government's compliance with its duty to respect the legitimate interests of the States." (citation omitted)).

To be sure, "so long as Congress' authority is limited to those powers enumerated in the Constitution, and so long as those enumerated powers are interpreted as having judicially enforceable limits, congressional legislation … always will engender 'legal uncertainty.'" *Lopez*, 514 U.S. at 566; *see also McCulloch*, 17 U.S. at 405 ("[T]he question respecting the extent of the powers actually granted, is perpetually arising, and will probably continue to arise, so long as our system shall exist."). But "[a]ny possible benefit from eliminating this 'legal uncertainty' would be at the expense of the Constitution's system of enumerated powers" and the integrity, dignity, and residual sovereignty of the States that it preserves. *Lopez*, 514 U.S. at 566; *cf. United States v. Morrison*, 529 U.S. 598, 620 (2000) (limitations on Congress' section 5 authority "are necessary to prevent the Fourteenth Amendment from obliterating the Framers' carefully crafted balance of power between the States and the National Government").

That is nowhere more true than in the spending power context. If the federal government were correct that there are no limits on Congress' ability to use its spending power to coerce the States, then "constitutional guarantees, so carefully safeguarded

against direct assault, [would be] open to destruction by the indirect, but no less effective, process of requiring a surrender, which, though in form voluntary, in fact lacks none of the elements of compulsion." *Frost & Frost Trucking Co. v. R.R. Comm'n*, 271 U.S. 583, 593 (1926); *see also Butler*, 297 U.S. at 71 ("The power to confer or withhold unlimited benefits is the power to coerce or destroy.").

This Court long ago confirmed that the judiciary has an obligation to ensure that the spending power does not become that kind of "instrument for total subversion of the governmental powers reserved to the individual states." *Id.* at 75. In keeping with that obligation, although the Court has acknowledged the difficulty inherent in determining "the point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 590, it has steadfastly refused to abandon the enterprise. *See id.* at 591 ("We do not fix the outermost line. Enough for present purposes that wherever the line may be, this statute is within it."); *Dole*, 483 U.S. at 211 (reaffirming coercion doctrine's existence); *Fla. Prepaid*, 527 U.S. at 687 (same). To do so now would be tantamount to abandoning the very framework of our system of constitutional governance.

II. The ACA's Amendments To Medicaid Are Unconstitutionally Coercive.

While this Court will surely confront difficult cases concerning the "point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 590, this is not one of them. Indeed, if the ACA does not cross the line, no Act of Congress ever will. Here,

Congress answered the coercion question itself by tying Medicaid to the individual mandate and premising its comprehensive health insurance reform scheme on the understanding that States had no realistic option but to expand Medicaid. The individual mandate gives low-income individuals no choice but to obtain insurance. And the Act provides no means for those individuals to obtain such insurance save Medicaid. A program necessary to satisfy a mandate cannot be understood as anything other than mandatory.

Congress itself recognized that States have no more choice to opt out of Medicaid than individuals have to opt out of the mandate. Indeed, States have less choice. While some individuals are exempt from the penalties designed to enforce the mandate, no State is exempt from the massive penalty—the loss of the entirety of funding under the single largest grant-in-aid programs for the States—and so Congress did not even contemplate the possibility of a State opting out of Medicaid. Elsewhere, where Congress provided States with meaningful choices, it provided a plan B. Not so with Medicaid. Congress provided no fallback because Congress itself recognized it was making States an offer they could not refuse.

A. The ACA Is Premised on the Understanding that It Forces States to Expand Medicaid.

The best evidence of the ACA's coercive effect is the ACA itself. "[I]t would make little sense for Congress to" devise a comprehensive scheme for "near-universal" health insurance coverage that

"leave[s] millions of the country's poorest citizens without medical coverage." Pet. App. 463a. It would make even less sense to issue an unprecedented command that virtually all individuals obtain health insurance and then provide no means by which millions of individuals could obtain the insurance necessary to satisfy that mandate. Yet that is exactly what Congress would have done if States' acceptance of the Medicaid expansion were truly voluntarily, as the ACA provides no means *other than Medicaid* through which the Nation's neediest residents might obtain insurance and comply with the mandate. Fear not. Congress' failure to provide an alternative to Medicaid was a product of neither imprudence nor oversight. Congress did not provide an alternative because it understood that it had not given States any meaningful choice to opt out. In reality, the States' "acceptance" of the Medicaid conditions is no less mandatory than the individual mandate itself.

The link between the Medicaid expansion and the need for all individuals, including low-income individuals, to obtain insurance is undeniable. They share an effective date, and Congress specifically recognized that Medicaid coverage satisfies an individual obligation under the mandate. *See* ACA § 1501(b), 26 U.S.C.A. § 5000A(f)(1)(A)(ii). Indeed, the ACA revolutionizes Medicaid to make it serve the mandate and the ACA's broader goal of near-universal coverage. Congress transformed Medicaid from a program designed to provide insurance to certain discrete categories of the needy, with substantial state discretion as to eligibility and the level of coverage, into one designed to provide a

minimum level of coverage to every needy citizen. In sum, Congress transformed Medicaid into a mandatory program specifically designed to supply insurance to the low-income individuals forced to obtain coverage by the ACA and its individual mandate. Congress provided no fallback for the neediest to obtain the insurance demanded by the ACA because a State's failure to participate in Medicaid was not just impractical, but inconceivable to the drafters of the ACA.

That lack of any contingency plan stands in stark contrast to other provisions of the Act in which Congress gave States a meaningful option and expressly accounted for the possibility that States might decline the federal blandishments. Most prominently, in providing for the creation of "health benefit exchanges" in each State, Congress authorized the federal government to establish and operate those exchanges in any State that chooses to forgo federal funding to do so itself. By deeming it unnecessary to acknowledge even the *possibility* that States might exit the Medicaid program rather than comply with the ACA, Congress confirmed its understanding that States quite literally could not afford to lose the billions of dollars in federal funding that the ACA puts at stake. *See* Pet. App. 462a ("Congress does not really anticipate that the states will (or could) drop out of the Medicaid program").[15]

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[15] The Court of Appeals erroneously assumed that the ACA does not require States to choose between adopting Congress' new conditions or opting out of Medicaid, and instead leaves the Secretary with discretion to allow States to continue

Other provisions of the ACA reflect that same understanding—namely, that State participation in Medicaid was not a matter open to choice. For example, Congress created tax subsidies for low-income individuals who purchase insurance, but it made those subsidies available only to individuals above the poverty level, meaning that most Medicaid recipients are not eligible for the new subsidies. *See supra*, pp. 12–13. As that limitation reflects, Congress saw no need to extend the subsidies to those below the poverty level because it was confident that Medicaid would continue to satisfy their insurance needs in every State. Indeed, Congress confirmed that its assumption that Medicaid coverage would be available explains its failure to extend eligibility to those below the poverty level when it crafted an exception to the income limit for individuals who are "*not eligible for the medicaid program* … by reason of [their] alien status." ACA § 1401(a) (adding § 36B(c)(1)(B)). No comparable exception was made for citizens living in States that opt out of Medicaid because Congress knew that was not a realistic option.

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participating in Medicaid without abiding by the ACA's new terms. *See* Pet. App. 62a (citing 42 U.S.C. § 1396c). The federal government does not defend that misconception. To the contrary, the federal government has conceded before this Court, as it has throughout this litigation, that the "categories of individuals to whom state programs must provide medical assistance, as well as the kinds of medical care and services the program must cover," remain requirements with which States must comply "[t]o be eligible for federal funds." Govt.'s Response Pets. Cert. 11.

Congress' understanding that the ACA would coerce States into expanding Medicaid is also reflected by a comparison with past amendments to Medicaid. For example, back in 1972, when Medicaid had not yet swelled to the massive funding levels of today, Congress chose *not* to make extension of coverage to all SSI recipients a condition of continued program participation because it "feared that [some] States would withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage." *Schweiker*, 453 U.S. at 38. To avoid that possibility, which was still a very real one in Medicaid's early years, Congress crafted an alternative for States that wanted to continue to participate at existing coverage levels. *See id.* at 38–39. The ACA demonstrates that Congress has overcome its fears and now legislates with confident knowledge that if it places the entirety of Medicaid funding at risk, States no longer have the ability to "withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage."

Other Medicaid amendments also evince Congress' grasp of the difference between persuasion and coercion and its purposeful decision to bring the latter to bear here. For example, at various points throughout the program's existence, Congress has offered *additional* funds to States that agreed to take on new obligations, rather than threatening to *withhold* all funds from States that were unwilling or unable to do so. *See, e.g.*, *supra*, p. 6 & n.6. Congress could have done exactly that here, by making coverage of newly eligible individuals a condition of receiving only *new* funding for those individuals, not of receiving *any* Medicaid funding—

nearly 40% of all funds the States receive from the federal government even before the massive expansion worked by the ACA.

To be sure, limiting the conditions to the new funding stream would have given States a meaningful choice whether to expand the Medicaid programs. But Congress did not want to give States a meaningful choice and so conditioned the entirety of Medicaid funding on the transformation of Medicaid. Because Congress knew that putting all Medicaid funding at risk would deprive States of any say in the matter, it provided no contingency plan for that inconceivable possibility. That approach may be far more efficient from Congress' perspective (indeed, every bit as efficient as legislation that explicitly compelled the States to act), but it is not an option Congress enjoys under the Constitution. Efficient or not, the Constitution "simply does not give Congress the authority to require the States to regulate." *New York*, 505 U.S. at 178.

In short, as Congress' own understanding of the ACA's operation reflects, while the line between persuasion and coercion may in other instances be "a question of degree," *Steward Machine*, 301 U.S. at 590, in this case it is not. "[T]he point of coercion is automatically passed," *Florida Prepaid*, 527 U.S. at 687, when Congress premises a comprehensive regulatory scheme on the understanding that States have no choice but to participate. "In such circumstances, if in no others, inducement or persuasion" necessarily goes "beyond the bounds of power." *Steward Machine*, 301 U.S. at 591. That the ACA rests on Congress' eminently reasonable assumption that no State could afford to withdraw

from Medicaid—indeed, Congress has not even established any mechanism by which a State might do so—is all the proof the Court should need to find the Act unconstitutionally coercive.

B. The ACA's Coerciveness Is Confirmed by Medicaid's Sheer Size and Congress' Attachment of New Terms to Pre-existing Funding.

The ACA threatens States with loss of *all* of their federal Medicaid funding if they do not capitulate to Congress' mandate that they dramatically expand their obligations under the program. The coerciveness of that demand is self-evident, as the sheer size of the federal inducement at stake puts this spending legislation in a class of one. Medicaid is already the single largest federal grant-in-aid program, accounting for a staggering 40% of all federal funds distributed to States and nearly 7% of *total* federal spending. In 2009 alone, most States received well over $1 billion in federal Medicaid funding—nearly a third of States received more than *$5 billion*. *See* Kaiser Found., *Medicaid Spending, FY2009*. The average State spends at least 20% of its *entire* budget on Medicaid, and federal funds cover no less than half (and oftentimes more) of each State's costs. NASBO Report, Table 5. And the ACA promises a massive expansion of the program and the amount of federal dollars devoted to it. No State could plausibly afford to forfeit all federal funding under a program of that unparalleled magnitude.

The coerciveness of the ACA is reflected not just in the sheer size of the federal inducement at stake, but in the fact that much of that inducement consists

of pre-existing Medicaid funding. When Congress makes new funds available, it obviously has substantial discretion to determine how those new funds are spent. Even then, the need to enforce meaningful limits on Congress' enumerated powers and the obvious reality that Congress is spending funds raised by taxes imposed on in-State taxpayers, thereby limiting States' ability to raise state taxes to replace those funds, demand some scrutiny. But when Congress seeks to condition not just newly available funds but pre-existing funding on a State's agreement to expand a program, the need for close scrutiny is heightened. The conscious decision to put at risk pre-existing funding streams for programs with 100% state participation and built-in constituencies means that Congress is not just imposing reasonable conditions on how funds may be spent, but using each State's—and each State's residents'—dependency on existing funding streams to coerce compliance with new conditions. And when both the pre-existing funding and the newly available funding are of unprecedented size, the coercion concerns are truly at their zenith.

That is precisely the situation here. By placing new conditions on continued receipt of all existing Medicaid funding (as well as on billions of dollars in new funding), Congress made clear that the ACA does not simply (or even primarily) fix the terms on which the substantial new funds it provides may be spent. It instead uses States' past decisions to participate in Medicaid to compel them to adopt, enforce, and even help fund a transformative program expansion, something Congress could not otherwise do without running afoul of the

commandeering doctrine. *See Butler*, 297 U.S. at 73 ("There is an obvious difference between a statute stating the conditions upon which moneys shall be expended and one effective only upon assumption of a contractual obligation to submit to a regulation which otherwise could not be enforced."). In other words, the ACA exploits each State's dependence on existing Medicaid funding—funding largely composed of federal tax dollars collected from States' residents who have come to depend on the return of those tax dollars to help fund critical medical care—to force States to continue participating in Medicaid under significantly altered terms.

Both the federal government and the Court of Appeals attempt to minimize the coerciveness of Congress' decision to put the entirety of Medicaid funding at risk by contending that Congress "reserved … the 'right to alter, amend, or repeal'" any aspect of the program. Pet. App. 60a (quoting 42 U.S.C. § 1304). But that both overstates what Congress reserved and confuses foreseeability and coercion. As to the former, States did not enter into Medicaid with notice—"clear" or otherwise, *see Pennhurst*, 451 U.S. at 17—that they were ceding to Congress the power to expand the program unilaterally and coercively. *See* 11th Cir. Amicus Br. for James A. Blumstein. States surely understood that by agreeing to participate in what was, at the time, a cooperative federal program, they did not obtain any vested right that the program would continue indefinitely or upon the same terms. But they by no means bargained away their right to insist that Congress not act coercively by conditioning continuing participation in the

unaltered aspects of the program on their "agreement" to expand the program massively.

What is more, even if Congress could reserve to itself the power to unilaterally and coercively alter spending programs, Congress did not do so here. Section 1304 merely reserves to Congress the right to "make such alterations and amendments [to Medicaid] *as come within the just scope of legislative power*." *Bowen v. Pub. Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 53 (1986) (emphasis added). It is not "within the just scope of" Congress' power to use past decisions to participate in Medicaid, and the entrenched dependence of existing constituencies that those decisions have generated, to hold States hostage to Congress' later demands.

In all events, even an express statement by Congress that it reserved the right to convert Medicaid from a voluntary program to a compulsory one would not deprive States of the opportunity to object when the conversion occurred. Coercion and forseeability are not the same things. A classic form of coercion is the threatening of future foreseeable harm. The salient point is not whether States had any warning that Congress might exploit their dependence on Medicaid funding to coerce compliance with a massive expansion of the program, but whether Congress' coercive action is permissible. It is not.

C. States Have No Realistic Alternative to Continued Participation in Medicaid.

The coerciveness of the ACA is not diminished by the observation that States "have the power to tax and raise revenue." Pet. App. 62a. Indeed, the

difficulty of declining massive funding streams that result from federal taxation that in turn saps the practical ability of States to raise their own revenues is part and parcel of the coerciveness of the ACA.

Federal spending is not a product of Congress' "generosity," *see* Govt.'s Response Pets. Cert. 15, in disbursing funds that materialize out of thin air. Federal funding is overwhelmingly composed of tax dollars collected from the States' own residents. Accordingly, when the federal government makes conditional funding offers to the States, it is "impos[ing] its policy preferences upon the States by placing conditions upon the return of revenues that were collected from the States' citizenry in the first place." *Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997). Were a State to refuse to comply with Congress' conditions, "federal taxpayers in [that State] would be deprived of the benefits of a return from the federal government to the state of a significant amount of the federal tax monies collected." *Jim C. v. United States*, 235 F.3d 1079, 1083 (8th Cir. 2000) (Bowman, J., dissenting). The larger the amount of the funds conditioned, the less realistic the State's purported option of turning down the funds. Its practical ability to ask residents, already taxed by the federal government to provide health insurance elsewhere, to contribute additional taxes to supplant the declined federal program is all but nil.

That point is critical. The analysis might be different if the massive amount of money used to induce the States to "accept" conditions came from some place other than taxpayers in the States. But there is no such pot of money. If a State were to

withdraw from Medicaid, "federal funds taken from [its] citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to the states that have agreed to continue participating in the program." Pet. App. 463a. Because the Medicaid funds used to induce the States come from their own taxpayers, the "option" of declining billions of dollars of federal funds and paying for medical care for the indigent through new taxes on in-State taxpayers who are already funding that care in the other 49 States is illusory. The choice given States is the equivalent of that offered by a pickpocket who takes a wallet and gives the true owner the "option" of agreeing to certain conditions to get the wallet back or having it given to a stranger.

To put the problem in concrete terms, in 2009, Florida collected less than $32 billion in taxes from its residents. *See* Fed'n of Tax Adm'rs, *2009 State Tax Revenue.*[16] That same year, the federal government collected a staggering *$110 billion* from Florida residents, approximately 10% of which—more than $10 billion—was returned to Florida in the form of Medicaid funding. *See* Kaiser Found., *Medicaid Spending, FY2009*; Mem. Supp. Pltfs.' Mot. Summ. J. 33 [R.E. 493]. Given the sheer size of Medicaid, Florida has no practical ability to inform its citizens that it will be declining that $10 billion and raising state taxes by 30% as a result, while the federal tax burden remains the same. That is even more true given that those numbers are based on the

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[16] Available at www.taxadmin.org/fta/rate/09taxbur.html.

assumption that funding its own alternative to Medicaid would cost Florida exactly the same amount as Medicaid, a rather unrealistic assumption in the short run given the substantial costs of getting a substitute program up and running. And those numbers do not account for the reality that the ACA will expand federal Medicaid spending by another $434 billion over the next decade, such that the burden on Florida's residents to fund health insurance in the other 49 States would be much greater going forward. *See supra*, p. 10. In short, the suggestion of simply raising taxes to fund an alternative to Medicaid is not "merely a hard choice," *Oklahoma v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981); it is no choice at all.

Precisely because States have no real choice in the matter, it is also irrelevant that Congress has given States what the Court of Appeals characterized as "plenty of notice" before many of the ACA's terms will take effect. Pet. App. 62a.[17] No amount of notice will render a coercive choice any less coercive. An extortionist who provides ample forewarning of his collection schedule may thereby maximize collections, but he does not lessen the

[17] Even assuming a mere four years constitutes "plenty of notice" for a State to raise billions of dollars to create an alternative to Medicaid, the States did not receive even that much notice as to all of the Act's terms. For example, the mandatory maintenance-of-effort provision *immediately* locked States into terms that States put in place when whether to do so (and whether to continue to do so) was voluntary. *See* ACA § 2001(b); *cf. Pennhurst*, 451 U.S. at 25 (Congress may not "surprise[] participating States with post acceptance or 'retroactive' conditions").

extortionate nature of his demands. Whether Congress gives States one year or ten years before the ACA's new conditions take effect, States have no realistic alternative to continued participation in Congress' dramatically expanded form of Medicaid.

Tellingly, the federal government has not made any real attempt to demonstrate that States could afford to turn down billions of dollars in Medicaid funding and go it alone. The federal government has instead attempted to change the subject. Like the Court of Appeals, *see* Pet. App. 61a, it places great emphasis on the fact that the States (at least initially) will pay only a small portion of the costs generated by the ACA's expansion. Even assuming the federal government were correct in its assessment of how much the ACA will cost the States (and the States vehemently dispute the federal government's projections), that argument reflects a fundamental misunderstanding of the relevant legal principles. Coercion is measured by how much a State stands to lose if it *rejects* Congress' terms, not by how much it stands to lose if it *accepts* them. That is why "the coercion inquiry focuses on the financial inducement offered by Congress," *Madison v. Virginia*, 474 F.3d 118, 128 (4th Cir. 2006) (internal quotation marks omitted), not how much money a State is "being coerced into spending," Pet. App. 61a–62a. When a thief produces a loaded gun and demands, "your money or your life," that demand is equally coercive whether the victim is carrying $5 or $500. Either way, given the alternative, "[t]he asserted power of choice is illusory." *Butler*, 297 U.S. at 71.

Indeed, given the practical effect on a State's ability to tax, the fact that the federal government's inducement is substantial only exacerbates its coerciveness. If the ACA offered States double the amount of their Medicaid expenditures if they would accept the new conditions, that double or nothing offer (with in-State tax dollars flowing out either way) would make the offer harder, not easier, to refuse, and would render any notion of meaningful choice that much more illusory.

But that power of choice is what the coercion doctrine is designed to protect. "It is an essential attribute of the States' retained sovereignty that they remain independent and autonomous within their proper sphere of authority." *Printz*, 521 U.S. at 928. The coercion doctrine ensures that independence and autonomy by safeguarding a *State*'s prerogative to determine whether Congress is offering a good deal or a bad one; Congress' insistence that it is the former cannot deprive States of that right. *See New York*, 505 U.S. at 168 ("by any … permissible method of encouraging a State to conform to federal policy choices, the residents of the State retain the ultimate decision as to whether or not the State will comply"). If anything, that Congress expects to increase federal Medicaid spending by *$434 billion* over the next decade therefore renders the ACA more coercive, not less, as States face the loss of even more federal tax dollars if they do not capitulate to Congress' new demands.

In all events, were Congress correct that the ACA is such an obvious bargain for the States, Congress would lose nothing by abandoning its coercive tactics, as States surely would accept the

new federal funds and conditions even without the threatened loss of billions in existing funding. Congress' unwillingness to give States that choice confirms its grasp of the dire circumstances States face. At a time when the federal government itself has recognized that States must significantly *decrease* Medicaid spending to return to fiscal stability, *see supra*, p. 18, Congress is effectively mandating at least a *$20 billion* increase in States' Medicaid spending over the next decade, with that amount only expected to continue rising thereafter. It is no wonder Congress will not give States—an unprecedented majority of which have joined this brief—a meaningful choice in the matter.

D. This Court's Precedents Support the Conclusion that the ACA Is Coercive.

This Court's decisions in *Steward Machine* and *Dole* also underscore the invalidity of the ACA's expansion of Medicaid. Although neither case held the challenged spending program unconstitutionally coercive, neither case presented a coercion claim of this magnitude. Nor did either present the straightforward case of a statute in which Congress itself confirmed that States had no choice but to comply. Nonetheless, the reasoning of both cases is directly on point.

Steward Machine involved a challenge to a new provision of the Social Security Act that imposed a federal unemployment tax upon certain employers but allowed a deduction of up to 90% if a State imposed its own tax to create an unemployment compensation program that satisfied certain federal requirements. *See Steward Machine*, 301 U.S. at

574. Thus, unlike in this case, where Congress provided no alternative to state compliance with Congress' conditions, in *Steward Machine*, Congress had provided a federal default option but given States a clear option to adopt an alternative. Not every State adopted the 90% option, but the State in question voluntarily did, and the coercion challenge that followed was brought by a private employer and resisted by the State, a factor upon which the Court placed great weight in finding the scheme non-coercive. *See id.* at 589 ("Even now [the State] does not offer a suggestion that in passing the unemployment law she was affected by duress.").

To be sure, "[w]here Congress exceeds its authority relative to the States … the departure from the constitutional plan cannot be ratified by the 'consent' of state officials." *New York*, 505 U.S. at 182. And the mere fact that some States are willing to accept Congress' terms is not enough, standing alone, to demonstrate that Congress has left them any other choice. That said, when no State even "suggest[s]" spending legislation is coercive, *Steward Machine*, 301 U.S. at 589, that is certainly a strong indication that States' acceptance of federal conditions was voluntary "not merely in theory but in fact." *Dole*, 483 U.S. at 211. That could not be farther from the case in this unprecedented action, in which more than half the Nation's States have joined forces to attest that Congress is forcing them to govern according to federal dictates that they would reject if given a meaningful choice.

A proper understanding of the Court's explanation for rejecting the claim presented in *Steward Machine* requires appreciation of the

unusual context of a coercion claim not supported by a State. When the Court cautioned that "to hold that motive or temptation is equivalent to coercion is to plunge the law into endless difficulties," *Steward Machine*, 301 U.S. at 589–90, it was rejecting the argument that spending legislation is *always* coercive—even when the States and the federal government are in agreement that it is not, and even when, as was the case there, other States had demonstrated their ability to reject federal funds by doing just that. *See id.* at 588 & n.9. In rejecting the extreme position that spending legislation is always coercive, the Court was hardly adopting the converse position that spending legislation can *never* be coercive. That could not be clearer from the Court's ultimate holding that, "in [these] circumstances, *if in no others*," coercion was not established, and its insistence that "[d]efinition more precise must abide the wisdom of the future." *Id.* at 591 (emphasis added); *see also id.* at 590 ("In ruling as we do, we leave many questions open."); *Dole*, 483 U.S. at 209 (asserting that *Steward Machine* "recognized" the existence of the coercion doctrine).

More fundamentally, *Steward Machine* is premised on an understanding of the spending power that is wholly inconsistent with the federal government's arguments in this case. When the Court rejected the coercion challenge presented in *Steward Machine*, it made clear its belief and expectation that, if States chose not to take advantage of the option of offsetting the federal unemployment tax with a tax of their own, the federal government would use the money collected through the federal tax to provide residents of such

States with some form of *federal* assistance. *See* 301 U.S. at 588–89; *see also id.* at 590 (characterizing State as having "chose[n] to have relief administered under laws of her own making, … *instead of under federal laws*" (emphasis added)). While the Court recognized that Congress was not expressly obligated to spend the tax receipts in any specific manner, *see id.* at 589, it did not so much as hint that Congress could impose the federal tax and do nothing for the unemployed in States that opted out. More to the point, the Court did not sanction a regime in which the federal tax dollars would be dedicated exclusively to supplementing state unemployment insurance programs in the States that opted in. If Congress had passed such a statute it would be analogous to the ACA, but it is impossible to think that the *Steward Machine* Court would have blessed that statute as constitutional.

By insisting that the ACA is *not* coercive because States have the "option" of forfeiting billions in federal Medicaid funding and assuming the full obligation of funding medical assistance for millions of their neediest residents while in-State federal tax dollars fund programs elsewhere, the federal government and the Court of Appeals turn *Steward Machine* on its head. *See* Pet. App. 62a. It is one thing for the Court to reject a coercion claim under the assumption that States may choose between accepting federal funds and accompanying conditions, or allowing the federal government to use equivalent funds to equivalent ends. *See Hodel*, 452 U.S. at 264. Such a program is akin to the real choice that the ACA offers States to create exchanges or have the federal government do so. It is quite another to reject

a coercion claim when the federal government not only insists that a State's sole alternative is for its residents to forfeit federal tax dollars entirely, but premises its whole regulatory scheme on the assumption that no State could possibly afford to do so. That is the non-choice offered States by the ACA when it comes to Medicaid.

In that respect, this case is more analogous to *New York* than to *Steward Machine*. The take-title provision held unconstitutional in *New York* interfered with state sovereignty by ordering States either to regulate radioactive waste pursuant to Congress' dictates or to assume full liability for waste generated within their borders. *See New York*, 505 U.S. at 174–75. The ACA interferes with state sovereignty by effectively ordering States either to regulate medical assistance for the needy according to Congress' dictates or to assume full responsibility for all medical assistance to the needy themselves. What is more, it does so while the federal government increases the costs by mandating that virtually everyone, including the neediest, maintain health insurance, while at the same time excluding the very neediest from federal subsidies designed to make that mandate more affordable. Once again, the individual mandate and the absence of any federal alternative for the very neediest belie the "voluntary" nature of the "option" given to States when it comes to Medicaid. Here, as in *New York*, "Congress has crossed the line distinguishing encouragement from coercion." *Id.* at 175. If anything, the coerciveness is even more profound in the ACA because States are, for practical purposes, *incapable* of assuming that financial burden so long

as Congress continues to collect billions of tax dollars from their residents to fund a massive spending program for which they will no longer be eligible.

Congress' decision to tie continued receipt of *any* Medicaid funding to acceptance of the ACA's new conditions also readily distinguishes the States' claim from the coercion claim rejected in *Dole*. There, Congress conditioned only 5% of federal highway funding—for South Dakota, approximately $4.2 million—on a State's agreement to establish a minimum drinking age of 21. *See Dole*, 483 U.S. at 211. That "relatively mild encouragement," *id.*, pales in comparison to Congress' threat to withhold the entirety of the single largest source of federal funding if States do not accept the ACA's terms. Indeed, many States received more than *1000 times* that amount in Medicaid funding in 2009 alone. *See* Kaiser Found., *Medicaid Spending, FY2009*. If the threatened loss of 100% of federal Medicaid funding—literally billions of dollars and nearly half of all federal funding—is not sufficient to pass the "point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 591, then the coercion doctrine itself is "more rhetoric than fact," *Dole*, 483 U.S. at 211.

III. Holding The ACA Unconstitutionally Coercive Will Not Lead To Wholesale Invalidation of Spending Legislation.

Whatever difficulties may lie in "fix[ing] the outermost line" at which "inducement or persuasion … go[es] beyond the bounds of power," *Steward Machine*, 301 U.S. at 591, this case does not require the Court to do so. Indeed, the risk is the opposite.

This case combines hallmarks of coercion—including Congress' expressed understanding that States have no alternative but to comply, the massive size of Medicaid, and Congress' decision to condition the entire funding stream on acceptance of the new conditions—that are unlikely to be replicated any time soon. The Medicaid expansion's mandatory nature and its uniqueness are both confirmed by its close relationship with the individual mandate, which all recognize is quite literally unprecedented. But while striking down the ACA's Medicaid expansion would endanger no other laws, upholding it would signal definitively that, when it comes to using established federal spending programs as leverage over the machinery of state governments, only Congress is guarding the henhouse. The sole guarantee of the fundamental division of authority between the States and the federal government, and the sole protection for the individual liberty that the division secures, would be Congress' "underdeveloped capacity for self-restraint." *Garcia*, 469 U.S. at 588 (O'Connor, J., dissenting).

The invalidation of the ACA and its illusory choice on Medicaid would not call into question the vast bulk of spending legislation because the ACA is unique in several material respects.[18] First, the

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[18] It would, however, necessitate invalidation of the entire ACA. For the reasons detailed in the Brief of State Petitioners on Severability, the Medicaid expansion is a critical component of Congress' supply-meets-demand scheme for "near-universal" health insurance coverage. ACA § 1501(a)(1)(D). Through the combined effects of the Medicaid expansion and the individual mandate, Congress envisioned an additional 16 million

individual mandate, which all concede is unprecedented, clearly informs the question whether the ACA's Medicaid provisions are voluntary. Federal statutes generally seek to achieve some objective, but do not purport to achieve near-universal compliance. In that normal context, if a State opts out and a federal objective is not fully achieved in a particular State, the federal program is not endangered and the State's opt out is an acceptable cost of our federal system. The individual mandate is different. By requiring nearly every individual to obtain a qualifying health insurance policy, the ACA cannot tolerate a State opting out. The consequence of an opt out—that individuals under a federal mandate to obtain insurance will have no means of doing so—is not one the ACA can abide. But that problem is unique to the ACA. It is the combination of the mandate and the absence of any alternative means of supply for the most needy that creates the irrefutable evidence that the choice is illusory when it comes to Medicaid. Since the individual mandate is unprecedented, so too is the coercion problem.

The lack of meaningful choice is then underscored by other provisions of the Act that evince Congress' understanding that the Medicaid

individuals—fully half of the 32 million individuals Congress expected to obtain insurance as a result of the Act—enrolling in Medicaid. CBO Estimate 9 (Mar. 20, 2010). Because the ACA could not function "in a *manner* consistent with the intent of Congress" absent the massive Medicaid expansion, *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), Title II cannot be severed from the balance of the ACA.

expansion is not voluntary. As noted, the Act provides federal alternatives when States are given meaningful choices whether to accept federal funds and makes arrangements for individuals not eligible for Medicaid to take advantage of federal subsidies. By providing no such alternative arrangements for achieving Congress' goal of near-universal insurance coverage in States that opt out of Medicaid, the Act confirms its coercive nature in a way that is unlikely to be replicated elsewhere.

Equally important, there simply are no federal spending programs of the same magnitude as Medicaid. Indeed, there are very few programs that could be characterized as coming anywhere close. According to the Census Bureau's report on federal aid to States in 2009, nearly half of spending programs disbursed less than $10 million in aid to all 50 States *combined*. *See* U.S. Census Bureau, Dep't. of Commerce, *Federal Aid to States for Fiscal Year 2009*, App. A & Table 1 (2010).[19] For about 200 programs, that number was less than $1 million. And as to some programs—even some of the larger programs—any coercion claim would be readily refuted by the fact that States not only can but often *do* turn down federal funds.

Even the largest federal spending programs are significantly smaller than Medicaid. Only about 5% of all federal programs distributed $1 billion *nationwide* in 2009, whereas Medicaid distributed more than that to most of the individual States. The

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[19] Available at http://www.census.gov/prod/2010pubs/fas-09.pdf.

second largest spending program (the Federal Aid Highways Program, at $35.6 billion nationwide) was less than one seventh the size of Medicaid ($256 billion) and disbursed $200 billion less. Other major initiatives such as Temporary Assistance for Needy Families and the Child Nutrition Program were less than one tenth the size of Medicaid. Combined spending on *all* of the different programs administered by the Department of Education—traditionally one of the largest sources of federal funding to States—was about $45 billion, less than a fifth of the amount disbursed under Medicaid.

Those figures are not meant to suggest that coercion concerns will never arise outside the context of Medicaid or its fiscal equivalent. But they do illustrate that the number of programs with the potential to raise coercion concerns of this magnitude is relatively small. Moreover, even as to the few programs large enough to present the opportunity for Congress to attempt to coerce the States, most coercion concerns still would arise only when Congress seeks to impose conditions on *entire blocks* of federal funding. Congress has many means of employing its spending power to achieve its policy objectives without resorting to that most drastic of measures. *See supra*, pp. 4–6.

To the extent that alternative means might be insufficient to achieve uniform compliance among the States, that is a virtue of the coercion doctrine, not a vice. *See Lopez*, 514 U.S. at 581 (Kennedy, J., concurring) (federalism ensures that "States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear"). When a

spending program becomes so massive that Congress and courts alike recognize that "a complete withdrawal of the federal prop in the system … could seriously cripple a state's" ability to function, *Harris*, 448 U.S. at 309 n.12, the Constitution should demand careful scrutiny of spending legislation that is deliberately crafted to exploit that reliance.

Indeed, the Fourth Circuit has recognized as much for years without invalidating any spending legislation or being bombarded with coercion claims. *See Madison*, 474 F.3d at 128 ("[A] Spending Clause statute that conditions an entire block of federal funds on a State's compliance with a federal directive raises coercion concerns."). As the Fourth Circuit's experience reflects, in the vast majority of instances, Congress does exercise its spending power constitutionally, and States do enter into (or decline to enter into) conditional spending programs "voluntarily and knowingly." *Pennhurst*, 451 U.S. at 17. All of that is but to say that recognizing a constitutional constraint on Congress' spending power under the unique circumstances here—where Congress expressly recognized that States had no choice but to comply and ensured as much by putting the entirety of Medicaid at risk—will prevent the worst abuses while preserving Congress' legitimate ability to "fix the terms on which it shall disburse federal money to the States." *New York*, 505 U.S. at 158.

By contrast, judicial approval of this unprecedentedly coercive legislation would signal the end to any meaningful judicial effort to curb Congress' exercise of the spending power. Whether the Court does so implicitly by upholding the

legislation or explicitly by embracing the federal government's position that "Congress *should* be able to place any and all conditions it wants on the money it gives to the states," Pet. App. 59a–60a, the consequences would be dire indeed. The federal balance on which our Constitution is premised could be circumvented by invocation of the spending power. Anything that Congress cannot achieve directly could be achieved indirectly through conditions on federal funds. Nothing would stop Congress from using its spending power to double or triple States' Medicaid obligations in the next bill, or from forcing States to impose an individual mandate to qualify for Medicaid funds.

Ultimately, the problem with the federal government's position is less the parade of horribles than the structural damage to our constitutional system. The scope of the federal government's power is much debated, but the fact that its powers are limited and enumerated is common ground to all. A judicial doctrine that implicitly or explicitly allows Congress to use the spending power without meaningful judicial supervision is simply not compatible with that basic premise of our system. Even when ascertaining judicially manageable lines is difficult, this Court has refused simply to "admit inability to intervene" when an exercise of Congress' power has "tipped the scales" of power too far in the federal government's favor. *Lopez*, 514 U.S. at 578 (Kennedy, J., concurring). If the Court declines to intervene even in a case like this, where Congress' coercion was open and notorious, it welcomes more of the same and risks tipping the scales of power irretrievably against the sovereign States.

CONCLUSION

For the foregoing reasons, the Court should hold the ACA's Medicaid expansion unconstitutional and therefore hold the ACA invalid in its entirety.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the Attorney General
Office of the Attorney General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

BILL COBB
Deputy Attorney General for Civil Litigation
Office of the Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

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Counsel for Petitioners

Statutory Appendix

TABLE OF CONTENTS

U.S. Const., art. I, § 8, cl. 1 .... 1a

U.S. Const., amend. X 2a

Relevant Provisions of the Patient
Protection & Affordable Care Act, Pub.
L. No. 111-148, as amended by the
Health Care & Education Reconciliation
Act of 2010, Pub. L. No. 111-152

Sec. 1501 .... 3a

Sec. 2001 .... 21a

Sec. 2002 .... 37a

Sec. 2304 .... 45a

U.S. Const., art. I § 8, cl. 1,

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States[.]

U.S. Const., amend. X

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

RELEVANT PROVISIONS OF THE PATIENT PROTECTION & AFFORDABLE CARE ACT, PUB. L. NO. 111-148, AS AMENDED BY THE HEALTH CARE & EDUCATION RECONCILIATION ACT OF 2010, PUB. L. NO. 111-152

SEC. 1501. [42 U.S.C. 18091]. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement 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. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to

increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the

other provisions of this Act, will significantly reduce this economic

cost. (F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase

health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement 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.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South- Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.— An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

"(b) SHARED RESPONSIBILITY PAYMENT.—

"(1) IN GENERAL.— If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

"(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

"(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) AMOUNT OF PENALTY.—

"(1) IN GENERAL.— The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

"(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

"(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

"(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1⁄12 of the greater of the following amounts:

"(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

"(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

"(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(B) PERCENTAGE OF INCOME.—As revised by section 1002(a)(1) of HCERA An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

"(i) 1.0 percent for taxable years beginning in 2014.

"(ii) 2.0 percent for taxable years beginning in 2015.

"(iii) 2.5 percent for taxable years beginning after 2015.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.— If an applicable individual has not attained the age of 18 as of the

beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

"(i) $695, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

"(i) the modified *adjusted* gross income of the taxpayer, plus

"(ii) the aggregate modified *adjusted* gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) MODIFIED ADJUSTED GROSS INCOME.— The term 'modified gross income' means gross income—

"(i) any amount excluded from gross income under section 911, and

"(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) RELIGIOUS EXEMPTIONS.—

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

"(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1) and

"(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) HEALTH CARE SHARING MINISTRY.—

"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

"(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

"(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

"(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

"(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income

for any portion of the required contribution made through a salary reduction arrangement.

"(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable

individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

“(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for ‘8 percent’ the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

“(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

“(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

“(4) MONTHS DURING SHORT COVERAGE GAPS.—

“(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by

minimum essential coverage for a continuous period of less than 3 months.

"(B) SPECIAL RULES.—For purposes of applying this paragraph—

"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

"(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

"(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

"(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

"(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

"(i) the Medicare program under part A of title XVIII of the Social Security Act,

"(ii) the Medicaid program under title XIX of the Social Security Act,

"(iii) the CHIP program under title XXI of the Social Security Act,

"(iv) the TRICARE for Life program,

"(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

"(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

"(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

"(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

"(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the

Secretary, recognizes for purposes of this subsection.

"(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

"(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

"(B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

"(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall

be treated as having minimum essential coverage for any month—

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) SPECIAL RULES.—Notwithstanding any other provision of law—

"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure.".

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking "or" at the end of subclause (VI);

(B) by adding "or" at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

"(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);".

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

"(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.".

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking "or" at the end;

(ii) in paragraph (25), by striking the period and inserting "; or"; and

(iii) by adding at the end the following:

"(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).".

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and

(B) by adding at the end the following new subsection:

"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

"(1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—

"(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

"(B) 95 percent for calendar quarters in 2017;

"(C) 94 percent for calendar quarters in 2018;

"(D) 93 percent for calendar quarters in 2019; and

"(E) 90 percent for calendar quarters in 2020 and each year thereafter.

"(2) DEFINITIONS.—In this subsection:

"(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual

described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

"(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).".

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by

paragraph (2)), is amended by inserting after paragraph (1) the following:

"(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

"(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.".

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking "and (XIV)" and inserting "(XIV)" and by inserting "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)" before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking "100" and inserting "133".

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),".

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII),".

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u– 7(a)(1)(B)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

(2) by adding at the end the following new subsection:

"(gg) MAINTENANCE OF EFFORT.—

"(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE

EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on

December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

"(4) DETERMINATION OF COMPLIANCE.—

"(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.— A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO

COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).".

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each";

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)" after "subsection (a)(1),";

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses

(vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph

(1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).".

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.".

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national

and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.— Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking "or" at the end;

(ii) in subclause (XIX), by adding "or" at the end; and

(iii) by adding at the end the following new subclause:

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);" and

(B) by adding at the end the following new subsection:

"(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xiii);

(ii) by inserting "or" at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

"(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),".

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(XIX),".

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting "or clause (ii)(XX)" after "clause (i)(VIII)".

SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

"(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

"(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income,

a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

"(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

"(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

"(D) EXCEPTIONS.—

"(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR

MEDICARE COST-SHARING.— Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

"(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

"(II) Individuals who have attained age 65.

"(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is

eligible for medical assistance on the basis of section 1902(e)(3).

"(IV) Individuals described in subsection (a)(10)(C).

"(V) Individuals described in any clause of subsection (a)(10)(E).

"(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

"(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

"(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or

community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

"(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

"(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection

(a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

"(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

"(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms 'modified gross

income' and 'household income' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

"(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

"(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

"(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.

"(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is

determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

"(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

"(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.".

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting "(e)(14)," before "(l)(3)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting “or the care and services themselves, or both” before “(if provided in or after”.