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Florida v. HHS - Amicus Brief of Governors of Washington, Colorado, Michigan, and Pennsylvania

Chris Gregoire
Office of the Governor of the State of Washington

The Honorable Roger Vinson

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through BILL McCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, *et al.*, Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	Case No. 3:10-cv-91

AMICUS BRIEF ON BEHALF OF THE GOVERNORS OF WASHINGTON, COLORADO, MICHIGAN, AND PENNSYLVANIA IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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I. INTRODUCTION

The Governors of Washington, Colorado, Michigan, and Pennsylvania (the "Governors") support the federal reforms embodied in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA" or the "Act"). Unlike the Attorneys General of their respective states who are plaintiffs in this action, the Governors believe that the Act is constitutional and consistent with the principles of dual sovereignty underlying our federal form of government.

For years, the Governors have grappled with growing problems of the availability of affordable health care for their residents, state agencies, and public employees, and the threats that rising health care costs pose to the economic vitality of their states. Given the huge scope of the problem and the interstate nature of the health insurance and health care markets, the Governors sought federal assistance in crafting a broader and more effective solution than the states would be able to implement on their own. The Governors actively participated in the political process that led to passage of the Act and believe that the Act is a reasonable and necessary response to these shared state and federal goals.

II. THE GOVERNORS RECOGNIZED THE UNSUSTAINABILITY OF THE STATUS QUO IN THE YEARS LEADING UP TO THE ACT

The state agencies for which the Governors are responsible are major purchasers of both health care services and health insurance, including programs that provide insurance, services, or prescription drugs to low income residents, state employees, injured workers, and prisoners in the state corrections systems. As a result, their state budgets have been severely impacted by the spiraling costs of services and insurance and declining access to affordable care. In recent years, health care costs have accounted for more than 20% of Colorado's operating budget and 28% of the operating budgets of Washington and Michigan.

Despite these expenditures, the states have suffered significant difficulties in meeting the health care needs of their citizens. The scope of the unmet need is illustrated by state-only programs that provide subsidized coverage for low-income adults without children who typically do not qualify for Medicaid. Washington's Basic Health program has more than 140,000 citizens who want to access the coverage but cannot due to state budget constraints. Pennsylvania's adultBasic program has a waiting list of 440,000 individuals.[1] Studies project that these shortfalls would only worsen in the absence of national health care reform.[2]

The high cost of health insurance also has negatively impacted economic growth in the states and their ability to participate effectively in interstate and international commerce. For example, health care costs contribute an estimated $1,200 to $1,600 to the price of every vehicle built by the domestic automobile industry, rendering manufacturers less able to compete with foreign automakers that pay a fraction of that amount.[3] Uncontrolled costs have stifled the growth of small businesses, created a disincentive for hiring new employees and dramatically reduced the availability of affordable insurance through employer group plans. Increasing numbers of small employers have dropped health care coverage for their

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[1] These programs illustrate why the Governors advocated for specific provisions in PPACA to meet state needs. Governor Gregoire worked with Washington's Congressional delegation to amend the legislation to afford states the opportunity to accelerate extension of Medicaid benefits to childless adults under the Act, providing an opportunity to substitute federal dollars for state funding of existing programs like Basic Health and Colorado's Health Care Affordability Act. *See* PPACA § 2001(a)(4).

[2] Bowen Garrett, et al., Urban Institute, *The Cost of Failure to Enact Health Reform: 2010-2020*, at 2 (Mar. 2010).

[3] Michigan.Gov, *What Health Care Reform Means to Michigan* <http://www.michigan.gov/healthcarereform> (last visited Nov. 18, 2010).

employees as a result of unpredictable rate spikes in the small group markets; for example, over 500,000 employees in Pennsylvania lost their coverage between 2001 and 2008.[4]

Finally, the states and their economies also have suffered from the high cost of uncompensated care caused by the lack of affordable insurance for large portions of their citizenry. The problem of the uninsured has impacted state budgets and economies in numerous ways, including: the shifting of costs through increased premiums paid by the states and other employers; subsidization by states of hospitals providing uncompensated care, including to uninsured patients from other states; and increased burdens on emergency responders, public health departments, and other social service systems funded by the states.

III. THE GOVERNORS SOUGHT THE ACT AS A NECESSARY FEDERAL RESPONSE TO AN INTRACTABLE NATIONAL PROBLEM.

Because of these severe challenges to their budgets and economies, the Governors welcomed a federal solution that would expand coverage, including to many whose health care is now wholly funded by the states, increase competition and affordability in the insurance market, and fund efforts to change health care delivery models and control spiraling costs. Plaintiffs portray the Act as a top-down initiative imposed on the states by federal fiat. In fact, the Governors advocated federal action to reform the nation's health care system and worked to shape the Act to meet states' needs. The Act is a product of the political dynamic in the federalist system, in which the federal government properly moved to address a problem that proved beyond the reach of the states alone, building upon the previous efforts of the states as "laboratories for social and economic experiment." *Garcia v. San Antonio Metro. Trans. Auth.*, 469 U.S. 528, 546 (1985).

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[4] Pennsylvania Office of the Governor, *Governor Rendell's Budget: Helping Families Weather the National Recession*, News Release at 2 (Feb. 4, 2009).

For years, each of the Governors, like many of their counterparts in other states, pursued state-level initiatives in an attempt to address the problems of health care costs, access to care, and affordable insurance. For example, in 2009, Colorado enacted its Healthcare Affordability Act, HB09-1293, to extend health care coverage to up to 130,000 uninsured Coloradans through use of a hospital provider fee. That Act also expanded Medicaid eligibility for children and pregnant women to 250% of the Federal Poverty Level ("FPL").[5,6] In Washington, Governor Gregoire's Blue Ribbon Commission on Health Care Costs and Access led to a number of major initiatives, including support for a "medical home" model of coordinated care, with financial incentives linked to improving health outcomes, rather than the number of procedures performed. *See* RCW 43.06.155. These efforts, while significant, informed the Governors' recognition that implementation of reform on a national level was necessary to realize their full benefits.

Thus, in February 2009, the bipartisan National Governors Association formed a Health Care Reform Task Force, with six Republican and six Democratic Governors, co-

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[5] In Pennsylvania, Governor Rendell's first Executive Order was to create an Office of Health Care Reform, which resulted in "Rx for Pennsylvania," a plan that emphasized the need to provide affordable care to the uninsured, assist primary care providers in managing chronic disease, and re-structure the small group and individual insurance market. *See* 4 Pa. Code §§ 6.251-6.255. The Governor achieved some success in implementing this program, but concluded that many key reforms required national action.

[6] In Michigan, Governor Granholm pioneered, with four other states, what has become the National Medicaid Pooling Initiative to generate significant savings from bulk purchasing of prescription drugs and created the MI-Rx drug discount program to make prescription medicines more accessible to Michigan's most vulnerable citizens. *See* Michigan Office of the Governor, *Michigan Welcomes Approval of Nation's First-Ever Multi-State Prescription Drug Pooling Program*, News Release (Apr. 22, 2004); *Granholm Unveils Michigan Prescription Drug Discount Card*, News Release (Sept. 21, 2004). Michigan also proposed the Michigan First Health Care Plan to create an affordable private insurance product for individuals and small businesses and subsidize care for those who could least afford it. Michigan Office of the Governor, *Talking Points: Michigan First Health Care Overview,* www.michigan.gov/documents/First_162550_7.pdf (last visited Nov. 18, 2010).

chaired by Governor Granholm and including Governors Rendell and Gregoire, that was designed to identify and define gubernatorial priorities and advise Congress and the Administration on health care reform.[7] Throughout the debate that led to passage of the Act, the Governors pointed to their own initiatives and experiences as models for the federal legislation. Many of the Act's provisions parallel and complement aspects of the state programs and initiatives described above, including in the areas of managed care, information technology, insurance market reforms, and expansion of publicly funded care to childless, indigent adults. The Act clearly builds on the experiences of other states, such as Massachusetts' experiment (under a Medicaid waiver) with universal coverage provisions.

The Act also embodies the lessons learned from unsuccessful state experiments. For example, Washington has experienced the "death spiral" that can occur in the insurance market when coverage for preexisting conditions is required without universal coverage. In 1993, the state adopted regulations governing individual health plans that prohibited denying enrollment because of health status and limited waiting periods to three months. Within a few years, insurance carriers began reporting significant market losses and premiums began to rise. The major carriers stopped selling individual plans, leading to the virtual destruction of the market.[8] In 2000, the legislature was forced to restructure underwriting for the private market: preexisting condition waiting periods were extended and insurers were allowed to screen out the most costly individuals. The state revived its dormant high risk pool to provide

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[7] *See* National Governors Ass'n, *NGA Creates Task Forces on Health Care Reform*, News Release (Feb. 23, 2009). In June 2009, Governors Granholm and Gregoire also were part of a bipartisan group of Governors that met with the Obama Administration to discuss health care reform and brief it on the results of regional fora that were co-hosted by the Governors and that brought together hundreds of diverse stakeholders to provide input on needed changes in the nation's health care system.

[8] *See* Washington Senate Bill Rep., E2SSB 6067, 56th Leg. (2000).

them coverage. PPACA's minimum coverage requirement builds on this and similar experiences in other states, to avoid the consequences that doomed the state initiatives.

As a further example, the Act includes provisions that create incentives for states to "rebalance" their Medicaid long-term care systems away from institutional care to home and community-based settings, where appropriate. *See* PPACA § 2401. This language was based on the experience in Washington with such rebalancing. And when states expressed concern about a proposal that would have extended Medicaid eligibility to childless adults up to 150% of FPL with an uncertain federal matching share,[9] Congress responded by restricting eligibility to 133% FPL and providing an initial matching rate of 100% and an ultimate federal match of 90%.

In short, the Governors worked with Congress and the Administration to craft a law that would allow for flexibility in implementation and financial and programmatic support for their own state initiatives. The policy choices embodied in the Act, including provisions on Medicaid expansion and universal coverage, were the result of a political process in which the states and their citizens had ample opportunity to be heard and in which the role of the states as laboratories for innovation was honored.

IV. THE "INDIVIDUAL MANDATE" DOES NOT INFRINGE ON STATE SOVEREIGNTY AND ADDRESSES INTERSTATE ECONOMIC PROBLEMS, INCLUDING THE COSTS OF THE UNINSURED WHO CROSS STATE BORDERS TO SEEK SPECIALIZED OR EMERGENCY CARE.

Plaintiffs have failed to acknowledge the lack of a relationship between the Tenth Amendment, the Commerce Clause, and their challenge to the individual mandate. The Tenth Amendment and the Commerce Clause are designed to protect state sovereignty, not

[9] *See* Kevin Sack & Robert Pear, *Governors Fear Medicaid Costs In Health Plan*, N.Y. Times, July 20, 2009, at A1.

individual rights. Moreover, given the interstate dimensions of the impact of the uninsured and the long history of joint federal and state involvement in the arenas of health care and insurance, there is nothing in the mandate that infringes on state sovereignty or "impairs the States' integrity or their ability to function effectively in a federal system." *Fry v. United States*, 421 U.S. 542, 547 n. 7 (1975). To the contrary, the Governors believe the mandate directly serves federalism by protecting the states from costs that otherwise would be imposed on their budgets and health care systems, not just by their own uninsured, but by uninsured residents of other states seeking care in their facilities as well.[10]

The cost of health care for the uninsured imposes substantial fiscal burdens on the states and their health care systems, businesses, and citizens. In Colorado, as many as 834,000 residents have no insurance; without health reform, one in five non-elderly Coloradans are expected to be uninsured by 2019.[11] In Michigan there are 1.2 million uninsured, with over 1,000 citizens likely to lose their insurance each week until 2011.[12] In Pennsylvania, more than 1 million residents, almost 10% of the population, are uninsured.[13] Nearly 876,000, or one in seven, non-elderly Washington residents have no health insurance;

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[10] Nor do the Governors believe that regulating "inactivity" is the exclusive province of the states. For example, if there were a nationwide spread of a pandemic disease, like the Spanish flu of 1918, which each state lacked the capacity to address on its own, it seems incontrovertible that Congress would have authority under the Interstate Commerce Clause to impose such measures as vaccination and screening of people on a universal basis, even with penalties for noncompliance far exceeding the fine that is the only consequence of refusing to buy insurance under the Act.

[11] New America Foundation, *The Future of Colorado Health Care*, at 3, 5 (2009).

[12] Michigan Dep't of Community Health, *Michigan Uninsured at a Glance* (Sept. 2009).

[13] Pennsylvania Insurance Dep't, *More Pennsylvanians Are Without Insurance & Health Care, Insurance Department Survey Shows*, News Release (Jan. 29, 2009).

that number is projected to reach 1 million by the end of 2011.[14]

The fact that these individuals are uninsured, however, does not mean they do not require health care. In Michigan, health care providers lose $2 billion in uncompensated care each year.[15] In Washington, uncompensated care provided by hospitals and other providers totaled almost $700 million in 2008.[16] In Colorado, the amount of uncompensated care in 2009 was $871 million; in Pennsylvania, $807 million was provided.[17] These costs impose substantial burdens on families and employers, including the states, because of cost-shifting to insured patients, and on state governments, which provide significant subsidies to hospitals and clinics with large volumes of uninsured patients. The states also are indirectly affected in their sovereign capacities by the increased costs and demands placed on hospitals, emergency responders, public health departments, and other social service agencies by the uninsured.

These costs are exacerbated because many individuals without insurance delay care until their conditions become more acute.[18] In addition to the negative health impacts of such delays, acute care and care for more advanced disease is typically more expensive than primary or preventative care.[19] Further, the uninsured often utilize hospital emergency departments as their primary care provider. Indeed, uninsured patients often cross state lines

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[14] Washington Office of the Insurance Commissioner, *A Problem We Can't Ignore,* at 1-2, 8 (Nov. 2009) (hereinafter, "*Washington OIC Report*").

[15] Michigan Health & Hospital Ass'n, *Record Medicaid Caseloads & Uncompensated Care, More People Losing Health Insurance Jeopardizing Hospital Safety Net*, News Release (Feb. 5, 2009).

[16] *Washington OIC Report, supra* note 12, at 2.

[17] New America Found., *supra* note 9, at 6; Pennsylvania Health Care Cost Containment Council, *Financial Analysis 2009 (Vol. 1), General Acute Care Hospitals*, at 12 (May 2010).

[18] Kaiser Comm'n for Medicaid & the Uninsured, *Low-Income Adults Under Age 65*, at 12 (June 2009); Institute for Medicine, *America's Uninsured Crisis,* at 5-8, 57-83 (2009).

[19] *Id.*; Families USA, *Paying a Premium*, at 12-13 (June 2005).

seeking care at safety net hospitals without barriers to access. Residents of southwestern Pennsylvania, for example, rely on access to West Virginia University Hospital ("WVUH"), *see West Virginia Univ. Hosps., Inc. v. Rendell*, 2009 WL 3241849, *14 (M.D. Pa. Oct. 2, 2009); and make over 1500 emergency room visits to WVUH each year, *West Virginia Univ. Hosps., Inc. v. Rendell*, 2007 WL 3274409, *2 (M.D. Pa. Nov. 5, 2007). West Virginia calculated that for fiscal year 2007 alone, the Commonwealth owed over $820,000 in payments for such visits to WVUH. *Rendell*, 2009 WL 3241849, *6.

Similarly, Harborview Medical Center in Seattle, operated by the University of Washington, is the only Level I trauma center for the four-state region of Washington, Alaska, Montana, and Idaho. Uninsured individuals who suffer catastrophic injuries from accidents and other unpredictable events are transported to Harborview for the care it can uniquely provide. In 2009 , Harborview cared for 12,028 patients from states in the region outside of Washington.[20] In the last five years, Idaho has paid Harborview $8,658,000 for uninsured and Medicaid patients from Idaho who received care.[21] Nationally, 18% of trauma center patients are uninsured; while a significant part of their costs of care remain uncompensated, some of that cost is covered by subsidies from the states to the centers.[22]

These state subsidies are provided through the "disproportionate share" program ("DSH") of federal-state payments to hospitals that serve large numbers of the uninsured. The cost of DSH payments to the states is substantial: for example, in Pennsylvania, total DSH payments to hospitals were almost $564 million in 2009; in Michigan, they were $431.6

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[20] Harborview Medical Center/University of Washington Medicine Response, Public Disclosure Request, June 2010 (copy available upon request).

[21] *Id.*

[22] National Found. for Trauma Care, *U.S. Trauma Center Crisis*, at 4 (May 2004).

million.[23] However, despite DSH payments, the volume of uncompensated care is becoming increasingly unsustainable for providers, particularly public safety net hospitals. For example, Harborview has gone from providing $27,041,000 in charity care in 2000 to $120,352,000 in 2008, of which only a portion is offset by DSH payments.[24]

Families and businesses who offer insurance to their employees also shoulder the burden of a system that cares for the uninsured in settings that do not provide the preventative or follow-up care that would reduce costs while providing better care. The increases in premiums and health care costs projected to occur, in significant part to pay for the uninsured, are staggering. For example, in the absence of reform, employer health care contributions in Colorado are expected to more than double by 2019, and family premiums would reach $22,706 by 2019.[25] The mounting cost of insurance has had an inevitable effect on the number of employers offering insurance and the number of individuals buying it. In Colorado, the vast majority of individuals who declined insurance offered by their employers gave the high cost as the reason for declining.[26] In Washington, 76% of employers insured their full-time employees in 2003; by 2008, only 56.5% of firms did.[27]

The cost of caring for the uninsured thus creates a downward spiral in which the unaffordability of insurance leads to increasing numbers of the middle class joining the ranks of the uninsured. Without the individual mandate and related insurance reforms under

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[23] National Health Policy Forum, George Washington University, *Medicaid Disproportionate Share Hospital (DSH) Payments*, at 1-2 (June 15, 2009).

[24] Washington State Dep't of Health, *Washington State 2000 Charity Care in Washington Hospitals*, at 10 (July 2002), and *Washington State 2008 Charity Care in Washington Hospitals,* at 9 (June 2010).

[25] New America Foundation, *supra* note 9, at 6, 13.

[26] Colorado Health Inst., *A Profile of Colorado's Uninsured Population,* at 9 (Nov. 2009).

[27] Washington State Employment Security Dep't, *2003 Employee Benefits Survey*, at 8 (March 2004) and *2008 Washington State Employee Benefits Survey,* at 5 (March 2009).

PPACA, state governments and health care providers would be forced to bear ever greater costs of treatment for uninsured people who suffer catastrophic medical events or fail to get screening that could avoid the development of significant medical conditions.

V. THE STATES ARE NOT COERCED BY THE ACT'S MEDICAID PROVISIONS.

As the courts have consistently recognized, Medicaid is a "cooperative federal-state program." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Plaintiffs argue that the Act creates a quantum change in the nature of Medicaid that "commandeers" state officers to implement a federal program. This is incorrect on several grounds.

First, states are not powerless to provide medical assistance to their poor in the absence of participation in Medicaid. States provided such assistance, in varying forms and degrees, prior to opting into the program. Indeed, Arizona, one of the plaintiffs here, waited until 1982 before joining Medicaid. Since joining Medicaid, many states' legislatures have designed and state executives have implemented state-funded programs, such as Washington's Basic Health program and Pennsylvania's adultBasic insurance program for poor, childless adults. While it is true that a program financed only by a state likely would be less extensive in terms of eligibility and services than one under Medicaid, that is a testament to the power of the joint federal-state enterprise, not its unconstitutionality.[28]

Second, plaintiffs disregard the history of Medicaid's evolution and the active role played by the states in its expansion over time. Since enactment, national enrollment in Medicaid has increased almost four-fold, from approximately 15 million people in 1969 to 55

[28] Plaintiffs also complain that if their states were to withdraw from Medicaid they would lose the tax dollars collected from their citizens to support the program. However, a similar dynamic did not render the unemployment insurance program unconstitutional in *Chas. C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937), which also involved a cooperative federal-state approach to an economic problem of national scope.

million covered today.[29] This expansion reflects both the needs met by the program and the tremendous benefits to the states from federal funding for the populations served.

This expansion has occurred in two ways. First, Congress has periodically expanded the populations for whom coverage is mandatory under Medicaid, from traditional welfare families, to elderly and disabled SSI recipients in 1972, to infants, children, and pregnant women at incrementally higher income levels between 1984 and 1990.[30] Second, the states periodically have extended optional coverage to higher income children, pregnant women, the disabled, and elderly as a matter of statutory right or through waivers from the federal government. In 2005, fully 29% of Medicaid enrollees were from "optional" eligibility groups, while 60% of Medicaid expenditures were for optional services.[31] Expansion of both mandatory and optional eligibility groups and services often has allowed states to access federal matching funds for programs that were previously funded entirely by the state. In Washington, for example, Medicaid expansion allowed the state to subsidize and expand existing state-funded programs for maternity care and poverty-level children. *E.g.*, RCW 74.09.800 (establishing maternity care program); RCW 74.09.405-450 (children's health program). In addition, expansion of mandatory eligibility groups often has followed extension of benefits to those populations by the states under the law's optional provisions,

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[29] By contrast, the Congressional Budget Office estimates that the Act will provide Medicaid coverage to an additional 16 million citizens by 2019, a substantial expansion but significantly less than the growth that has occurred from the program's enactment to the present. January Angeles & Matthew Broaddus, Center on Budget & Policy Priorities, *Federal Government Will Pick Up Nearly All Costs of Health Reform's Medicaid Expansion,* at 1 (April 20, 2010).

[30] Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid:A Timeline of Key Developments* <http://www.kff.org/medicaid/medicaid_timeline.cfm> (last visited Nov. 18, 2010).

[31] Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services*, at 1 (June 2005).

exemplifying the states' role as laboratories for reform and trailblazers in the ongoing evolution of the program.[32]

PPACA's extension of mandatory eligibility to poor, childless adults continues this history. As with prior expansions, this measure will provide substantial federal funding for programs in many states that cover low income adults and are currently wholly state funded. It follows the lead of at least seven states that presently cover low-income childless adults under existing Medicaid waivers.[33] Federal subsidies for private insurance for individuals above 133% FPL also will allow states covering such adults ultimately to shift them from state-financed programs to the private market, at federal expense.[34] Thus, the Act continues the pattern of beneficial cooperative federalism that Medicaid has always embodied.

Third, the Governors reasonably view this Medicaid expansion as an affordable and preferable alternative to the costs that their states would have faced, without any federal assistance, to underwrite health insurance for poor, childless adults or to subsidize uninsured care for such populations. One projection estimates that the Medicaid expansion will help significantly reduce the more than $25 billion that states spend on hospital care and mental health services for the uninsured each year, while increasing state Medicaid expenditures between 2014 and 2019 by only $20 billion in aggregate.[35] While these projections may turn

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[32] *See* Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 Health Care Financing Review 45, 51 (Winter 2005-2006).

[33] Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform*, at 3 n.1 (May 2010).

[34] While the Act contains maintenance of effort requirements over the short term, states ultimately retain the flexibility, if they want, to offset some of the costs of the new mandatory requirements by adjusting their current coverage of optional services and optional populations, which, as explained above, represents a significant portion of overall Medicaid spending.

[35] Angeles & Broaddus, *supra* note 29, at 1.

out to be more or less accurate, far from feeling commandeered by the Act's expansion of Medicaid, the Governors support this measure due to its benefits for the health of their poorest citizens and its potential for savings in other areas of their state health care budgets.[36]

As noted above, the mix of mandatory and optional eligibility, benefit, and rate elements in Medicaid has repeatedly shifted in response to policy decisions, the national economic and political climate, and the interplay between the federal government and the states. The states have not been passive players in this process and have often obtained changes to make the program more amenable to their needs.[37] Although, as here, individual states have opposed certain changes to the law at one time or another, that is hardly unusual in a partnership involving all 50 states and does not undermine the program's status as a cooperative venture in which the states greatly benefit.

Moreover, plaintiffs' request that this Court decide what is "affordable" for the states proposes a far greater intrusion on state sovereignty than any of the challenged Medicaid provisions. "Affordability" is a quintessentially political question involving policy choices about revenues and expenditures within a state's mandatory and optional Medicaid budgets and between health care and other state programs. *See Mitchell v. Johnston*, 701 F.2d 337, 352 (5th Cir. 1983). Nor can plaintiffs enunciate a principled basis on which the Court can

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[36] For example, Pennsylvania, estimates the Act would save the state between $283 and $651 million through 2018 as a result of higher drug rebates, rebalancing to home and community based care, reduced PACE costs, and reduced need for state funded CHIP. Pennsylvania Office of the Governor, *Governor Rendell Signs Order Starting to Implement Health Care Reforms*, News Release (May 19, 2010).

[37] *See, e.g.*, *Wilder*, 496 U.S. at 505-06 (describing history of amendments "to give States more flexibility to develop methods and standards for reimbursement"); *id.* at 517 (describing repeal of measure requiring states to waive 11th Amendment immunity in response to opposition from the states); Pub. L. 109-171, 120 Stat. 4, 81, §§6041-6044 (loosening restrictions on cost-sharing by higher-income recipients under state plans).

make this determination. Indeed, by plaintiffs' logic, since Medicaid already is so vital to the states that they have no choice but to participate, the existing program must be discarded as violating the Tenth Amendment, even absent the PPACA amendments.

Finally, how can a court determine whether the potential $20 billion cost to the states of Medicaid expansion under the Act is less "affordable" than the $200 billion in increased Medicaid costs and costs of the uninsured that they might face in the absence of federal health care reform? It is the shared duty of the states, their Governors, and the federal government to provide for the health and welfare of their citizens. The alternative to national reform would be for states to continue bearing the costs of the uninsured and categorically ineligible populations (like low-income, childless adults) without federal assistance. For these reasons, the Governors not only accepted, but endorsed expansion of the federal-state partnership under Medicaid to assist in provision of basic medical care to these citizens.

VI. CONCLUSION

For the reasons stated above, the Governors of Washington, Colorado, Michigan, and Pennsylvania believe PPACA does not infringe on state sovereignty and is within Congress' constitutional authority.

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