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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

Case No.: 3:10-cv-91-RV/EMT

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STATE OF SOUTH CAROLINA, by and through
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STATE OF GEORGIA, by and through SONNY PERDUE, GOVERNOR OF THE STATE OF GEORGIA;

STATE OF ALASKA, by and through DANIEL S. SULLIVAN, ATTORNEY GENERAL OF THE STATE OF ALASKA;

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, a California nonprofit mutual benefit corporation;

MARY BROWN, an individual; and

KAJ AHLBURG, an individual;

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHLEEN SEBELIUS, in her official capacity as the Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF THE TREASURY; TIMOTHY F. GEITHNER, in his official capacity as the Secretary of the United States Department of the Treasury; UNITED STATES DEPARTMENT OF LABOR; and HILDA L. SOLIS, in her official capacity as Secretary of the United States Department of Labor,

Defendants.
____/

REPLY IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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Plaintiffs hereby submit this reply in support of their Motion for Summary Judgment [Doc. 80-1] ("Pl.MSJ"). As shown below, Defendants' Memorandum in Opposition ("Def.Opp.MSJ") [Doc. 137] fails to controvert Plaintiffs' showing that no genuine issue of material fact exists and that Plaintiffs are entitled to judgment in their favor as a matter of law on Counts One and Four of the Amended Complaint. Accordingly, the Patient Protection and Affordable Care Act[1] ("ACA" or "the Act") should be declared unconstitutional and its enforcement enjoined.

Argument

I. STANDING, RIPENESS, AND JUSTICIABILITY ARE ESTABLISHED

Contrary to Defendants' assertion, Plaintiffs, through sworn submissions and other evidence, clearly demonstrate injuries that are "concrete and particularized" and "actual or imminent, not 'conjectural' or 'hypothetical.'" *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (citations omitted). Individual Plaintiffs Brown and Ahlburg both attest to specific and cognizable injuries. Brown, for example, describes how the Individual Mandate, to which she objects, will force her to divert resources from her business. Pl.App. Ex. 25 (Brown Decl.) [Doc.80-6] ¶ 9. That Brown must, in addition, "investigate whether and how to both obtain and maintain the required insurance" only increases, rather than vitiates, her other injuries. *Id.* at ¶ 10. *See also* Pl.App. Ex. 26 (Ahlburg Decl.) [Doc. 80-6] ¶¶ 8, 9 (testifying to similar injuries). By selectively quoting from the Individual Plaintiffs' declarations, Defendants misrepresent the injuries

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

described by Plaintiffs. Def.Opp.MSJ at 3-4 (asserting that Brown, Ahlburg, and NFIB declarants claim only the need to investigate how to obtain coverage in the future).

Moreover, as the Court found based on the Amended Complaint's allegations, the injuries to which Individual Plaintiffs and NFIB members now attest – which are entirely consistent with those allegations – are sufficiently imminent to support standing: "the date is definitively fixed in the Act and will occur in 2014, when the individual mandate goes into effect and the individual plaintiffs are forced to buy insurance or pay the penalty." Mem. Op. 32. "[O]ne does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough." *Id.* at 32 (quoting *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979)). Far from hypothetical, Plaintiffs' injuries will occur by operation of statute.

Defendants also challenge the standing of nine of the twenty Plaintiff States, on the grounds that these States did not submit declarations to show injury caused by the ACA. But the Court already has rejected such a divide-and-conquer tactic where, as here, the standing of other parties is established. Mem. Op. 36 (citing*, e.g.*, *Vill. of Arlington Heights v. Metro. Housing Dev. Corp.*, 429 U.S. 252, 264 n.9 (1977)) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to maintain this suit."). Furthermore, while the Court did not address the Plaintiff States' distinct bases for standing, they have established all facts sufficient to support their standing both to challenge the Individual Mandate – which, as shown, will drive millions of additional persons onto the States' Medicaid rolls – and to challenge the ACA's transformation of Medicaid. Indeed,

Plaintiffs' coercion and commandeering claim is established from the ACA's language, federal government documents, and established sources upon which Defendants themselves rely. See PSOMF [Doc. 80-2] ¶ 15; Pl.MSJ at 32 n.25, 41 n.38 & n.39. Thus, Plaintiffs have established their standing to bring this challenge.

II. THE INDIVIDUAL MANDATE IS UNCONSTITUTIONAL

A. The Individual Mandate Cannot Be Sustained under the Commerce Clause Alone or Together with the Necessary and Proper Clause

Plaintiffs have meticulously demonstrated that the commerce power only reaches activity. Activity is key in *all* of the relevant case law. References to "activity" and "conduct" permeate judicial decisions applying that power, which never has been used to compel inactive persons to enter into commerce. Pl.MSJ at 5–9. This limitation applies regardless of whether the power is predicated upon the Commerce Clause alone or in combination with the Necessary and Proper Clause. Pl.MSJ at 23 n.20. *See Gonzales v. Raich*, 545 U.S. 1, 561 (2005) (Scalia, J., concurring); *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1250–52 (11th Cir. 2008) (citing *Raich*, 545 U.S. at 25). Despite repeated opportunities to do so, Defendants have been unable to cite a single pre-ACA decision applying the commerce power to inactive persons or compelling anyone to engage in commerce against his or her will. Defendants' complete failure in this critical respect is dispositive; the Individual Mandate cannot stand.[2]

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[2] Defendants mischaracterize the *Gold Clause Cases*. Def.Opp.MSJ at 12. The requirement that individuals possessing gold bullion, gold coins, or certificates must exchange them for United States currency only impacted persons actively in possession of the goods at issue, much like the possession of marijuana at issue in *Raich*. In both cases, individuals could avoid congressional regulation by the simple expedient of *not* possessing the subject item. *See Norman v. Baltimore & O. R. Co.*, 294 U.S. 240, 304

Significantly, Defendants no longer maintain that compelling individuals to have healthcare insurance is itself a regulation of interstate commerce. Rather, they argue that such coverage may be compelled because the failure by individuals to have insurance in the aggregate "substantially affect[s] the interstate health care market, and indeed, the entire U.S. economy." Def.Op.MSJ at 7. This is allegedly so because the Individual Mandate supposedly regulates future purchases of healthcare *services* by regulating the means of payment for such care, and because compelling individuals to have coverage is "essential" to the success of ACA's "insurance market reforms." *Id.* at 6. These arguments, based on alleged *effects* of inaction on interstate commerce, purport to be rooted in the Necessary and Proper Clause. However, they distort Supreme Court jurisprudence,[3] and unconstitutionally seek to use the Necessary and Proper Clause to grant a broad general police power to the federal government.

1. <u>Defendants Assert Unlimited Power</u>

Defendants improperly conflate the power to regulate commerce with the power to regulate persons. Congress has the power to regulate the transactions or other

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(1935). The same cannot remotely be said of the Individual Mandate. Defendants' continued reliance on *Heart of Atlanta Motel v. United States*, 379 U.S. 241 (1964), as a claimed instance in which commercial activity was compelled, is likewise flawed. This Court itself already has rejected that claim. Op. Mem. at 63.

[3] Defendants continue to misapply the Necessary and Proper Clause factors identified by the Supreme Court in *United States v. Comstock*, 130 S. Ct. 1949 (2010), and fail to overcome Plaintiffs' showing that all *Comstock* factors weigh decisively against the Individual Mandate. Pl.MSJ at 18-20. The mandate, impacting hundreds of millions of persons, is neither "modest" nor "narrow." And while the federal government has, in limited respects, "regulated the field of health insurance for decades," Def.Opp.MSJ at 15, it has no "history of involvement," *Comstock*, 130 S. Ct at 1968, in mandating coverage. Defendants concede that the mandate is unprecedented. *Id.* at 12 n.8.

economic activities of persons while they are engaged in commerce, but individuals' participation in some transactions in some markets does not give Congress police power to regulate their behavior *generally* or to compel them to engage in other forms of commerce involuntarily. The "commerce power" (the Commerce Clause as augmented by the Necessary and Proper Clause), *Garcia,* 540 F.3d at 1249, permits Congress only to regulate the activities of individuals who *already* are in a particular market or engaged in *activity* that is subject to federal regulation. This point is made repeatedly in the case law, as noted, and Defendants cannot dispute it.

Defendants struggle unsuccessfully to satisfy this test.[4] Everyone, they claim, is *always* in the "market" for medical services, and the mandate merely regulates how payment will be made for those services. Recognizing the unlimited breadth of such asserted authority and the constitutional necessity of a limiting principle to "withhold[] from Congress a plenary police power that would authorize enactment of every type of legislation," *United States v. Lopez,* 514 U.S. 549, 566 (1995), Defendants claim that the healthcare market is "unique" – not because of any one factor, but because of a "unique combination of features." Def.Opp.MSJ at 7. They are wrong, both factually and legally.

2. <u>The Supposed Uniqueness of the Healthcare Market Is Neither True Nor a Meaningful Limiting Principle</u>

The "combination of features" Defendants identify – necessity, variability, unpredictability, and the potential for catastrophic expense, Def.Opp.MSJ at 8 – is no

[4] In an effort to avoid the requirement of activity, Defendants can cite only irrelevant instances in which Congress compelled activity relying on *other* enumerated powers. Def.Opp.MSJ at 12 n.7. Further, unlike the commerce power, none of those other powers, even exercised to their limits, threatens to usurp the general police power that the Constitution reserves to the States. *See* Pl.Opp.MSJ at 17-18.

more unique to the healthcare *services* market (let alone the market for healthcare *insurance*) in combination than taken individually.[5] First, necessity, variability, and unpredictability are not unique to the healthcare market; they are the basic characteristics of the human condition and hence would not limit the authority asserted by Defendants. Food, shelter, clothing, and transportation are continual necessities of modern life, but every individual's ability to secure these basics is subject to an extraordinary number of variables. By Defendants' logic, it would make more sense to claim that everyone is always in the market for these items rather than for healthcare services, which they concede individuals may not need for extended periods of time. Def.Opp.MSJ at 8. Likewise, catastrophic costs are not unique to healthcare. The loss of a home to fire, wind, or water also imposes such costs on the homeowner (and may be borne by others if, as a result, there is a mortgage default). All of these features extend to many markets.

Second, individuals are in a better position to regulate their consumption of healthcare services than of these other necessities of life. They can do little to avoid either the need for these necessities, or the possibility of catastrophic costs in securing them. By contrast, it is untrue that "one can do relatively little to adjust one's consumption of health care to one's income." Def.Opp.MSJ at 8. Individuals "adjust" their consumption of healthcare services by choosing providers and treatment options – just as they determine where to live, the type of transportation to use, and what foods to buy. Moreover, contrary to Defendants' contention, one can minimize vulnerability "to

[5] Defendants earlier argued, without support, that the purchase of insurance could be compelled due to the "unique" combination of universal participation and the possibility of cost-shifting. Def.MSJ at 33. Here again, Defendants offer no support for claiming that this new combination of features expands Congress's power. Def.Opp.MSJ at 8-9.

an expensive disease or a serious accident" through healthy living and caution. *See, e.g.,* National Cancer Inst., Cancer Prevention, http://www.cancer.gov/cancertopics/prevention. To that end, millions of Americans jog, diet, and avoid carcinogens.

Third, "uniqueness" fails as a meaningful limiting principle. If individuals can be required to have healthcare insurance, then they can be required to behave in any manner Congress dictates. Indeed, all aspects of individual behavior affect health and wellbeing, and thus healthcare consumption. If, as Defendants allege, Congress can require individuals under the Necessary and Proper Clause to purchase insurance to ensure that the insurance industry does not collapse, then surely it can require individuals to engage in behavior designed to minimize their projected healthcare services consumption. This follows because there is no meaningful distinction between the ACA's Individual Mandate, which would increase insurance companies' revenues from premiums, and any wellness mandates, which would lower insurance companies' outlays for healthcare services.

Fourth, the paternalism inherent in Defendants' "catastrophic expense" argument is the hallmark of the police power and unrelated to regulable commerce. The police power "springs from the obligation of the state to protect its citizens and provide for the safety and good order of society." *Panhandle E. Pipe Line Co. v. State Highway Comm'n*, 294 U.S. 613, 622 (1935). Congress's concern for potential catastrophic

expenses befalling individuals (and the potential economic consequences) may be addressed only by regulating activity in, or substantially affecting, interstate commerce.[6]

Fifth, uniqueness fails as a limiting principle because it is vague and impossible for the courts to administer. Several of the supposedly "unique" aspects of the healthcare services market – variability and unpredictability – make it *less* suitable for regulation than markets in which transactions are more consistent and predictable. Indeed, the greater the certainty of future transactions, the stronger the basis for regulation and compulsion under Defendants' logic. The other factors – necessity, potential for catastrophic costs at the individual level, and cost-shifting at the market-wide level – also are ill-defined and impossible for courts to cabin. Food, clothing, housing, and even generalized financial stability are all "essential" to the wellbeing of citizens and the economy as a whole. Courts would be unable to deny congressional findings about such matters when the next case arose. Also, "catastrophic consequences" being vague, courts could not define or effectively limit congressional action to redress only them, as distinct from "severe" consequences. This would allow Congress to decide for itself when and how broad a police power it may exercise. No useful limiting principle would remain.

[6] It is Congress's imposition of a mandate directly on virtually every American under the *commerce power*, regardless of any actual economic or commercial activity in which individuals may be engaged, that violates the Constitution. The federal government having no general police power, *Lopez*, 514 U.S. at 566, it must regulate through its enumerated powers. Interpreting those powers so broadly as to encompass a plenary police power would deliver a fatal blow to the role of the States in our constitutional structure. If there is no authority exercised by the States that is denied to the federal government, and the federal government's dictates take precedence under the Supremacy Clause, then the States are relegated to mere administrative units of the always-supreme federal government. That States must remain sovereign is clear from *New York v. United States*, 505 U.S. 144 (1992), and *Printz v. United States*, 521 U.S. 898 (1997).

3. <u>**The Mandate Is Not Essential to Congress's Actual Regulation of Interstate Commerce**</u>

The Necessary and Proper Clause is not itself an enumerated power, capable of operating on its own, but is meant to aid in the exercise of Congress's enumerated powers. Accordingly, Necessary and Proper Clause analysis "look[s] to see whether the [Necessary and Proper-based] statute constitutes a means that is rationally related to the *implementation of a constitutionally enumerated power*." *Comstock,* 130 S. Ct. at 1956 (emphasis added); *see also United States v. Darby*, 312 U.S. 100, 121 (1941) ("Congress ... may choose *the means* reasonably adapted *to the attainment* of the permitted end ....") (emphasis added). Yet, although the Individual Mandate is the ACA's keystone, it is not related to the *implementation* of Congress's insurance industry regulations and is not "essential" to them, as that term is used in *Raich* and similar cases. *See e.g., Raich*, 545 U.S. at 36 (Scalia, J. concurring). As those cases indicate, Congress can reach commercial *activity*, including intrastate *activity*, where necessary to implement its regulation of interstate commerce – e.g., where "the regulatory scheme could be undercut unless the intrastate *activity* were regulated." *Id.* (quoting *Lopez*, 514 U.S. at 561).

Defendants fundamentally misconstrue the nature of the Necessary and Proper Clause, Def.Opp.MSJ at 11, casting it as a license to legislate the *downstream effects* of, as opposed to the *means of implementing*, specific Commerce Clause-based regulations. Because the Individual Mandate addresses the *downstream cost consequences* of Congress's prohibition of insurers' denials of coverage for preexisting conditions (the so-called "guaranteed issue" regulation), rather than being a *means of implementing* the proper exercise of Congress's commerce power, the Necessary and Proper Clause does

not authorize it. Nor can Defendants' claim that the Mandate is "essential to … guaranteed issue," Def.Opp.MSJ at 14, change this analysis. The Necessary and Proper Clause is not an infinitely capacious gap-filler. An expansion of jurisprudence pertaining to that clause to encompass such regulation of downstream effects would subvert the clause's plain meaning and create unlimited federal power to calibrate the economic effects of countless laws (most of which have some economic consequence) by compelling individuals to engage in specific commercial activity.

The Constitution authorizes powers, not "objectives," Def.Opp.MSJ at 11, and the Necessary and Proper Clause only serves "to carry into execution the constitutional powers of the government." *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 420 (1819).[7] The test, therefore, is not whether the Individual Mandate or other Necessary and Proper Clause-based regulation is essential to achieving a desired economic result or a particular market outcome – be it universal healthcare coverage or preventing insurers' collapse – but whether it is necessary and proper for Congress to exercise its commerce power to regulate interstate commerce.

Raich illustrates this point. The *intra*state marijuana regulation was both essential to and non-remote from its *inter*state regulation: the intrastate market could not be

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[7] Asserting that, because an "objective falls within the Commerce Clause," Def.Opp.MSJ at 16, Congress may adopt any means to achieve it, would transform the Necessary and Proper Clause into a plenary police power *exceeding its actual enumerated powers and making them redundant*. But the Necessary and Proper Clause merely affords the means to exercise enumerated powers, and is inherently constrained. By contrast, a Necessary and Proper Clause that empowered Congress to achieve "objectives" would support regulations that are decoupled from the exercise of any enumerated power, bestowing an infinitely capacious authority on Congress.

"hermetically sealed off from the larger interstate marijuana market." *Raich,* 545 U.S. at 30. Unlike the impossibility of enforcing an interstate ban on commerce in marijuana in the face of an intrastate marijuana market, the requirement that individuals purchase insurance does nothing to carry into execution Congress's power to regulate the insurance industry.[8] A person's decision to buy insurance does not impact the regulated terms of policies sold by insurance companies. With or without the mandate, "guaranteed issue" and "community rating" still could be implemented and act as *effective* regulations. *See* Pl.MSJ [Doc. 80-1] at 18 n.17. As Defendants acknowledge, the mandate seeks to ameliorate the natural *downstream cost* of the ACA's insurance regulations.

Congress always must act "within the scope of the constitution"; the Necessary and Proper Clause does not transcend the limitations on its power. *McCulloch*, 17 U.S. at 420-21.[9] Given Defendants' fundamental misconception regarding the proper object of any asserted necessity under the Necessary and Proper Clause, and the breadth of the unlimited authority arising under the Defendants' reasoning, such claimed authority is not necessary and proper within the meaning of the Constitution and must be rejected.

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[8] Unlike, for instance, a law requiring that insurance companies keep books and records, be audited, and be subject to penalties for noncompliance, the Individual Mandate is not a *means* of implementing or executing Congress's regulation.

[9] Moreover, in asserting that the mandate is necessary to ensure that "insurance as a viable means of financing health care services will continue to exist," Def.Opp.MSJ at 11, Defendants claim for Congress the power to implement otherwise *ultra vires* provisions to fix problems *created* by Congress. By this logic, the more damaging Congress's regulatory scheme, the greater Congress's power to ameliorate its effects.

B. The Individual Mandate Is Unlawful in All of Its Applications Because It Is Beyond Congress's Constitutional Authority

The Individual Mandate is "unconstitutional in all of its applications" because Congress lacks the power to enact it, and it is therefore facially unconstitutional. *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 449 (2008) (citing *United States v. Salerno*, 481 U.S. 739 (1987)). That Congress *might* have constitutionally reached only active insurance market participants with a different statute cannot save the ACA from Plaintiffs' facial challenge. The law must stand or fall as Congress wrote it.

Defendants' assertion to the contrary, Def.Opp.MSJ at 9–10, also is plainly inconsistent with, *inter alia*, *Lopez* and *United States v. Morrison*, 529 U.S. 598 (2000). The *Lopez* Court held that Congress facially lacked the power to reach the class of activity defined on the face of the statute. 514 U.S. at 567. This result obtained even though Congress might have reached some conduct related to its regulatory scheme (*e.g.*, firearms transactions in school zones). But this is not what Congress did; the statute it enacted regulated activity untethered from the commerce power. *Id*. at 551. To uphold the legislation would "bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States." *Id*. at 567. *Accord Morrison*, 529 U.S. at 598, 618–19. The Individual Mandate is substantively the same as these provisions and, therefore, also is invalid. Hence, the Court no more can "blue-pencil," *Free Enterprise Fund v. Public Accounting Oversight Board*, 130 S. Ct. 3138, 3162 (2010), the ACA to rescue the mandate on an as applied basis, than it can sever the balance of the ACA from the clear failure of its central provision (discussed in Part IV, *infra*).

III. THE ACA EXCEEDS CONGRESS'S SPENDING POWERS BY UNDULY COERCING AND COMMANDEERING THE PLAINTIFF STATES

Defendants fail to meet and overcome Plaintiffs' showing in support of summary judgment in their favor on Count Four. The ACA's transformative changes to Medicaid are indisputable, and the States cannot avoid those changes – as Congress was well aware when it passed the ACA. Indeed, in transforming Medicaid to suit its new objective of near-universal healthcare coverage, Congress knew that it was going far beyond the mere persuasion of a funding "carrot," and that instead it was wielding a "stick" over the States in violation of federalism and dual-sovereignty principles.

A. The ACA "Transforms" Medicaid and Foists Harmful New Obligations on the Plaintiff States

Defendants cannot dispute the fundamental changes that the ACA makes to Medicaid. They cannot contest that under the ACA:

- Medicaid eligibility standards now are expanded to include everyone making an income up to 38 percent *above* the federal poverty line, where the pre-ACA Medicaid's eligibility standards only extended to persons actually in poverty or falling within limited categories of demonstrable *need*;
- States now are to be responsible for *providing* healthcare services, where the pre-ACA Medicaid only required States to *reimburse* healthcare costs incurred by the poor and needy;
- the federal government will continue to share the cost of Medicaid reimbursements, but it will *not* share the States' ACA-imposed burdens and costs of providing healthcare services; and

- States' ability to control their Medicaid outlays will be curtailed by the ACA's new maintenance of effort requirements.

Defendants seek to minimize these changes by mischaracterizing them as consistent with prior refinements to Medicaid eligibility criteria. But those adjustments were designed to benefit other needy groups of individuals: the elderly, the infirm, and children.[10] As such, they were consistent with the voluntary undertaking to which the States had committed in joining Medicaid in the first place. It is patently unreasonable to assert the same about the ACA's changes, which will swell Medicaid enrollment by *30 percent* to require – for the first time – inclusion of all healthy, childless adults with incomes up to 138 percent of the poverty level.[11]

The ACA's elevation of eligibility standards to well above the poverty line for all people, including healthy childless adults, signals that the ACA's Medicaid revisions are designed not to benefit the poor and needy, but to address another and quite distinct goal: *viz.*, the achievement of near-universal healthcare coverage.[12] In that regard, it is

[10] *See*, *e.g.*, Br. of Am. Acad. Of Pediatrics et al. as Amici Curiae [Doc. 134] at 5-14.

[11] *See* Kaiser Comm'n on Medicaid & the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform*, July 2010, at 1 ("Health reform will expand Medicaid to millions of low-income adults, including childless adults who have historically been ineligible for the program, necessitating one of the largest enrollment efforts in the program's history.").

[12] That some States, for their particular Medicaid programs, had generously increased eligibility criteria prior to the ACA is of no moment here. Those States clearly understood that they retained the sovereign power to eliminate those increases. In fact, prior to the ACA just 39 percent of Medicaid spending involved congressionally-defined core groups and services that States were obligated to offer. Pl.Supp.App. [Doc. 135-1] Ex. 7 (Anna Sommers, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories*, Kaiser Comm'n on Medicaid & the Uninsured, June 2005, at 11). The ACA substantially reconfigures Medicaid's calculus

noteworthy that the Medicaid changes at issue were not enacted independently, but as a key component of the ACA's architecture. The widening of the Medicaid "door" to accommodate 18 million additional persons is integral to the ACA's overall design – *but not integral to Medicaid as it existed prior to the ACA.*

The ACA further advances its universal coverage objective by imposing on the States the new obligation to provide healthcare services themselves. As Plaintiffs have demonstrated, this obligation entails costs and liabilities so massive that no one yet has offered an estimate as to the dollar impact on the States. Contrary to Defendants' argument in the lone footnote they devote to this entire topic, that these costs presently are incalculable in no way lessens their severity – or their significance in demonstrating that Medicaid truly has been transformed by the ACA. Def.Opp.MSJ at 21 n.14.

The burden on the States from having to provide healthcare services is greatly intensified by the serious looming shortage of providers, including Medicaid providers, as Plaintiffs further have shown, citing and quoting federal sources. Pls. MSJ [Doc 80-1] at 42 n.42.[13] Defendants do not dispute the shortage or its severity, and do not dispute

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for the States by requiring that they enroll 18 million more individuals – including healthy adults who are not in poverty and who do not have children.

[13] In addition to CMS, the Association of American Medical Colleges projects that "[t]he passage of health care reform, … will increase the need for doctors and exacerbate a physician shortage" along the following lines:

- Between now and 2015, the year after healthcare reforms are scheduled to take effect, the shortage of doctors across all specialties will quadruple. While previous projections showed a baseline shortage of 39,600 doctors in 2015, current estimates bring that number closer to 63,000, with a worsening of shortages through 2025.

that the federal government already has programmed future reductions in rates of provider compensation.

Plaintiffs rightly have noted that the burden of providing services puts the States in a terrible dilemma: either (1) somehow find the *additional* monies to induce adequate numbers of providers to participate in Medicaid on behalf of the ACA-expanded pool of eligible recipients; or (2) face potentially huge liabilities and the possible loss of all federal funding for failing to meet the ACA's requirements. Coercing the States to foot the bill for shoring up the supply side of healthcare in the face of projected provider shortages is consistent with the ACA's goal of universal coverage, but it is a vast departure from the Medicaid program that existed up to the time the ACA was enacted.

Defendants also acknowledge that the ACA immediately applied maintenance of effort provisions against the States that restrict their ability to control costs. Def.Opp.MSJ at 28. Indeed, CMS already has threatened a Plaintiff State's funding over failure to abide by the ACA's maintenance of effort requirement.[14] Defendants cannot

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- There also will be a substantial shortage of non-primary care specialists. In 2015, the United States will face a shortage of 33,100 physicians in specialties such as cardiology, oncology, and emergency medicine.
- With the United States Census Bureau projecting a 36 percent growth in the number of Americans over age 65, and nearly one-third of all physicians expected to retire in the next decade, the need for timely access to high-quality care will be greater than ever.

https://www.aamc.org/download/150584/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf (last visited Dec. 6, 2010); https://www.aamc.org/newsroom/newsreleases/2010/150570/100930.html (last visited Dec. 6, 2010).

[14] *See* Pl.App. [Doc. 80-6] Ex. 33 (CMS Letter from Acting Director Barbara K. Richards to Monica Curry, AZ Off. of Intergovernmental Relations, April 1, 2010) (threatening to withhold Arizona's entire $7.8 billion annual Medicaid funding if it failed to comply with the ACA's new maintenance of effort provision).

dispute that this requirement was imposed in furtherance of the ACA's goal of universal coverage, reflecting Congress's view that States' flexibility should be curtailed in favor of achieving that goal.

There is no room for reasonable disagreement. The ACA has radically transformed Medicaid into something that is far different, immeasurably costlier, and designed to function as a part of a much broader scheme with a new objective.

Neither *Harris v. McRae*, 448 U.S. 297 (1980), nor *Bowen v. POSSE*, 477 U.S. 41 (1986), affords any defense to Plaintiffs' claims. *Harris*, in discussing Medicaid as a partnership to aid the poor and needy rather than as a means for achieving universal coverage, does not license Congress to transform Medicaid in any imaginable manner that it sees fit. Rather, *Harris* simply deals with the provision and funding of discrete Medicaid services. It does not address the lawfulness of Congress pulling a bait-and-switch by transforming the purpose and burdens of Medicaid in the context of tying it to another, much larger scheme.

Bowen, which does not involve Medicaid at all, is even further afield. There, the Court determined that Congress could require State and local workers to participate in the social security program notwithstanding these workers' entry into the program via a voluntary agreement between the federal government and States that later wished to leave the program. But *Bowen* does not stand for the proposition that Congress can pull bait-and-switch shenanigans with the States under the Spending Clause. Instead, the Court permitted State and local workers to be locked into the program at issue there because of its relationship to Congress's broad power to regulate commerce. Congress believed that

a change in economic conditions necessitated new regulations to protect workers, and Congress could not have contracted away its sovereign power to legislate in this area. *Id.* at 51-52.[15] *Bowen* did not suggest the evisceration of the Court-recognized Spending Clause limitations advanced in *South Dakota v. Dole*, 483 U.S. 203 (1987), and *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937). On the contrary, since *Bowen* was decided, the Supreme Court has positively discussed the coercion-by-financial-inducement principle in both *College Savings Bank v. Florida Prepaid Postsecondary Educational Expense Board*, 527 U.S. 666, 687, 697 (1999), and *Sabri v. United States*, 541 U.S. 600, 608 (2004). Here, just as with the Individual Mandate, Defendants' analysis utterly fails to accept that Congress's powers over the States and the People are limited.[16]

B. The ACA Gives States No Option To Avoid the New Medicaid Regime

As Plaintiffs have shown, there is no mechanism for the States to withdraw from Medicaid, much less to effect an orderly transition out of Medicaid that would protect the lives and health of the millions of poor and needy persons who depend on Medicaid. Plaintiffs further have shown that the States, alone, cannot emulate the Medicaid program. Defendants do not dispute any of this.

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[15] One year prior to *Bowen* the Court held that Congress could regulate workplace conditions of State and local workers. *See Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

[16] Defendants' citation to *Benning v. Georgia*, 391 F.3d 1299, 1308 (11th Cir. 2004), and proportionality misapprehends the Plaintiffs' argument and adds nothing to the analysis. Plaintiffs do not contend that the ACA's new Medicaid conditions are minor as compared with federal Medicaid disbursements, but that Medicaid has been transformed and the States must accept its transformation, all-or-nothing, or lose tens of billions of dollars in federal funds. Both the law and the funding at issue here are enormously consequential.

Yet, Defendants still assert – as they must, to avoid losing this lawsuit – that the ACA's new Medicaid regime is voluntary, and that States can withdraw as they choose.

However, Defendants scrupulously avoid any discussion of the central role that Medicaid now plays in the ACA's structure, as the only "door" by which the poor and needy can obtain coverage in compliance with the Individual Mandate. Nowhere do Defendants show any other avenue for the poor and needy to get coverage. Nowhere do Defendants explain how the ACA possibly could function if States pulled out of Medicaid. Nowhere do Defendants offer any justification, if States withdrew from Medicaid, for leaving the poor locked out in the cold on their own while tens of millions of relatively well-off Americans would receive federal assistance. Defendants' silence speaks volumes, effectively conceding that Congress knew, in fashioning and then passing the ACA, that the States could not walk away from Medicaid – no matter how great the burdens Congress chose to impose on them.

Congress's understanding that the States are stuck in Medicaid is entirely consistent with the other key facts supporting Plaintiffs' position – all undisputed here:

- that Medicaid on average comprises 20 percent of States' budgets;
- that the States cannot emulate Medicaid-level programs on their own – and, in Florida's case, such an attempt would consume more than half of its revenues;
- that Medicaid represents the single largest federal grant program to the States, some $251 billion per year as of 2009;
- that the ACA's Medicaid program will spend an additional $434 billion over base levels in the next eight years;
- that federal Medicaid funds represent the needed return to the States of resources taxed away from their residents and businesses by the federal government; and

- that if a State could withdraw from Medicaid, its citizens still would be required to pay taxes to fund Medicaid programs of other participating States.

It is clear that the federal government, aware of its coercive clout, intends to make the States comply with all of the ACA's new Medicaid requirements. *See* Def.Opp.MSJ at 24 ("if the state continues to receive federal matching payments, it would be expected to comply with the [ACA's] requirements").[17]

Defendants' only answer is that a State can drop out of Medicaid by seeking to amend its Medicaid plan. *See* Def.Rep.MTD [Doc. 55] at 5 n.2. But, as Plaintiffs previously have noted, "amending" and "ending" are not the same, and in any event an amendment requires the *permission* of CMS – an unelected federal agency – indicating that CMS possesses the authority to say no. By Defendants' own reckoning, insofar as Medicaid is concerned, when it comes to sovereignty, the States have none.[18]

Thus, Defendants find themselves in an unsustainable quandary. The ACA's *functionality* depends on the States *not* being able to withdraw from Medicaid. But the ACA's *constitutionality* depends on the States being able to withdraw. The only rational resolution is to strike down the ACA.

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[17] Though Defendants vaguely suggest that the HHS Secretary might exercise discretion and penalize States only partially for noncompliance (Def.Opp.MSJ at 25), clearly no option is presented for States to disregard the ACA – see CMS's threat to Arizona (*supra* n.14). The States face an all-or-nothing proposition: accede to the ACA's substantial new requirements or forgo all funding. *See* Def.MTD at 9 [Doc. 55-1] ("States can accept federal funds *and* the accompanying conditions, or not.") (emphasis in original).

[18] That some States are driven to explore the possibility of opting out of Medicaid is not surprising, given the ACA's harsh terms. But this does not mitigate the ACA's unlawful coercion of the States, which must comply with the ACA's terms until such time as suitable replacement systems could be conceived and implemented despite the tremendous losses of federal funding.

C. **The ACA's Medicaid Regime Unlawfully Coerces the States and Commandeers Their Resources**

Defendants dispute none of the basic facts on which Plaintiffs' coercion and commandeering claim rests. Instead, Defendants persist in arguing that Plaintiffs' coercion claim is essentially nonjusticiable. Def.Opp.MSJ at 34. They do so despite this Court's rejection of their motion to dismiss Count Four. Mem. Op. 56-57. And they continue to misplace reliance on decisions from other circuits that involve far less coercive scenarios or disregard the Supreme Court decisions acknowledging coercion-based limitations on Congress's Spending Clause authority.

The Supreme Court repeatedly has recognized limits to Congress's power to use dollars to pressure States: "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach.*, 301 U.S. at 590); *see also United States v. Butler*, 297 U.S. 1, 78 (1936); *Coll. Sav. Bank.*, 527 U.S. at 687; *Sabri*, 541 U.S. at 608 (coercion claims valid where "federal economic might [is brought] to bear on a State's own choices of public policy").

While Defendants contend that coercion claims must fail regardless of the size or scope of the financial inducement, the Supreme Court says otherwise. In *Steward Machine,* the Court stated that "the point at which pressure turns in to compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact." 301 U.S. at 590. Analysis in two more recent opinions also shows that the size and scope of dollars withheld make all the difference in adjudicating coercion claims. *Compare Dole,* 483 U.S. at 211 (withholding 5 percent ($4 million) of certain highway funds not

considered coercive) *with Coll. Sav. Bank*, 527 U.S. at 697 (Breyer, J., dissenting) (deeming it "compelling and oppressive" if funds were withheld from a $20 billion or $21 billion federal program).[19]

The Supreme Court's analysis directs the focus here to whether the sums that the federal government would withhold for failure to comply with the ACA-amended Medicaid program – $251 billion per year in base Medicaid spending plus $434 billion more over the next eight years – are amounts that the Plaintiff States can freely reject "of [their] unfettered will, [and not] under the strain of a persuasion equivalent to undue influence." *Steward Mach.*, 301 U.S. at 590. Plainly, these unprecedented sums far surpass the point of coercion, as matters of both law and common sense.

As noted above, it is clear that Congress itself, in erecting the structure of the ACA, knew that its financial coercion would enable it to impose vast new burdens, transforming Medicaid and linking it to a wholly new federal program with a wholly new objective. That is, Congress knew that its funding gave it the clout to engage in what, in comparing pre- and post-ACA Medicaid programs, amounts to a bait-and-switch. Earlier Medicaid amendments that added or adjusted eligibility categories to accommodate more poor, aged, or infirmed individuals comported with the program's original purpose to which the States voluntarily subscribed. The same is not true of the ACA's Medicaid regime, which substantially expands eligibility to accommodate a new federal goal.

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[19] Defendants' discussion, Def.Opp.MSJ at 35 n.22, of *College Savings Bank* conveniently ignores that Justice Scalia's majority opinion agrees with Justice Breyer's dissent that Congress's Spending Clause powers "in cases involving conditions attached to federal funding … might be so coercive as to pass the point at which pressure turns into compulsion." 527 U.S. at 687 (citing *Dole* and *Steward Machine*).

Moreover, Congress, in passing the ACA, knew that the States' continued participation in Medicaid was essential: withdrawal would undermine the ACA's raison d'être, as no other coverage provision was made for this population. At the same time, Congress also had to know, in imposing such severe costs and care responsibilities on the States, that their continued participation in Medicaid was unavoidable. Otherwise, Congress surely would have refrained from overburdening the States as it has done. CMS exhibited the same arrogance just one week after the ACA's passage by threatening a State's entire Medicaid funding. CMS, too, was secure that, even though that State's withdrawal from Medicaid would thwart the ACA's mission, it would not take place.

Congress's awareness of its coercive power is further demonstrated by the Hobson's choice it has imposed on the States: accede to Congress's new Medicaid regime and drive their budgets off a cliff, or suffer the loss of all Medicaid funding. Defendants' response, that the States actually will save money under the ACA, is exposed as utterly preposterous in Pl.Opp.MSJ [Doc. 135] at 31-33.[20] Regardless, the focus in coercion claims is not on how much States will be forced to pay under Congress's new program, but on how much they stand to lose if they refuse to capitulate.

Thus, the ACA's Medicaid regime both unduly coerces the States with enormous financial inducements in violation of the principle repeated in *Butler*, *Steward Machine*,

[20] As Plaintiffs show, Defendants' primary reliance is misplaced on a pre-ACA report by the President's Council of Economic Advisers, whose putative savings actually come not at the State level, but at local levels that will not benefit State budgets at all. Indeed, these so-called savings, stemming from localities' projected reduced need to make up for underpayments to providers, are likely to result in a shifting of costs to the States – which, as noted, must somehow find the money to induce providers to offer their services to Medicaid recipients. In any event, any savings to the States would be collateral to the costs and obligations which they must assume under the ACA.

Dole, and *College Savings Bank*, and violates federal commandeering limits because "[t]he Federal Government may not compel the States to enact or administer a federal regulatory program." *New York*, 505 U.S. at 188; *see also Printz*.

D. All Five *Dole* Spending Clause Restrictions Have Been Violated

Defendants' responses to Plaintiffs' showing that all five *Dole* Spending Clause restrictions have been violated must be rejected for the reasons set forth above and in Plaintiffs' prior submissions. The ACA's Medicaid regime threatens States' ability to provide for the health and safety of their neediest residents, and thus cannot fairly be characterized as furthering the general welfare. The bait-and-switch as between the pre- and post-ACA Medicaid programs underscores that Medicaid has not been conditioned on unambiguous terms, and that its fundamental purpose has been changed. The ACA's forcing of the new Medicaid on the States violates their sovereignty, and unlawfully coerces them and commandeers their resources. The ACA should be struck down.

IV. THE ACA SHOULD BE DECLARED UNCONSTITUTIONAL IN ITS ENTIRETY, AND DEFENDANTS SHOULD BE ENJOINED FROM ENFORCING IT

Plaintiffs have established that the Act's Individual Mandate and Medicaid provisions are unconstitutional. Because each is essential to the ACA as a whole, neither can be severed, as a matter of law. Defendants offer no sound reason for avoiding this result. That numerous relatively trivial aspects – *e.g.*, indoor tanning salon provisions – are hung from the structure of the ACA affords no basis for allowing any part of the Act to stand. There is no support for any argument that Congress would have passed any

portion of the ACA in the absence of its main components, in particular the Individual Mandate and the four "doors" for complying with it, including the new Medicaid regime.

Likewise, Defendants offer no reason for the Court to refrain from enjoining the enforcement of the ACA by the Defendants. If, as Defendants suggest, the declaration of unconstitutionality is sufficient, then surely an injunction would add no harm. If, however, there is any risk that in its absence Defendants might seek to enforce the Act, then an injunction is entirely appropriate. Regardless, Defendants cannot get around the long history of legal authorities, cited in Pl.MSJ at 49-50, in which federal courts have exercised their equitable powers to prevent violations of constitutional rights.

Conclusion

For all the reasons stated above and in Plaintiffs' initial memorandum, summary judgment should be entered in Plaintiffs' favor on Counts One and Four of the Amended Complaint; the Patient Protection and Affordable Care Act, as amended, should be struck down as unconstitutional; and the relief sought in the Amended Complaint should be granted in its entirety.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 6th day of December, 2010, a copy of the foregoing Reply in Support of Plaintiffs' Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

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