No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, *et al*.,

Petitioners,

v.

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 the States of Oregon, Vermont, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, and New York, and the Governor of Washington as Amici Curiae in Support of Respondents

(Addressing Medicaid Expansion)

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QUESTION PRESENTED

Does Congress exceed its authority under the Spending Clause by expanding eligibility for Medicaid and by giving the Secretary of the Department of Health and Human Services discretion to withhold some or all Medicaid funds from States that fail to implement that expansion?

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INTEREST OF AMICI STATES

Amici, the States of Oregon, Vermont, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, and New York, and the Governor of Washington, have no more important duty than protecting the health and safety of their citizens. To fulfill that duty, amici must ensure that their citizens have access to affordable health insurance. Amici also have a vital interest in ensuring that the federal government respects constitutional principles of federalism. Amici have long been committed to finding innovative ways to improve access to quality health care for their citizens and have a particular interest in reforms that do not encroach on State autonomy or restrict States' ability to shape healthcare policy. The Patient Protection and Affordable Care Act of 2010 ("ACA") is a comprehensive national solution to the nation's healthcare crisis that embraces principles of cooperative federalism and allows the States to substantially expand and improve health insurance coverage.

The ACA achieves increased coverage through a variety of mechanisms, including an expansion of the Medicaid program. The law will expand Medicaid eligibility to nearly all non-elderly adults who earn up to 133% of the federal poverty level ("FPL"). While some States have already expanded Medicaid eligibility to those levels, the vast majority have not. Nationally, the expansion is expected to decrease the number of uninsured persons by approximately 11.2 million, or 45% of uninsured adults below 133% of the

FPL.[1] In Oregon, for example, the ACA reforms will allow the State to reduce the number of uninsured to just 5% by 2019—a vast improvement over the 23.8 to 27.4% rate of uninsured predicted without the reforms.[2]

Those gains in coverage will come at little or no cost to the States. Although more people are expected to enroll in Medicaid under the ACA, the federal government will cover virtually all of the costs of newly eligible enrollees. As a result, Medicaid enrollment nationally is estimated to increase 27 percent by 2019, but average State spending will increase by only 1.4 percent.[3] Without healthcare reform, however, the States face the possibility of increasing enrollment without supplemental federal funding.

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[1] Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform* 10, tbl. 1 (May 2010), *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

[2] Bowen Garrett et al., *The Cost of Failure to Enact Health Reform: Implications for States* 51 (Oct. 1, 2009), *available at*: http://www.urban.org/uploadedpdf/411965_failure_to_enact.pdf

[3] Kaiser Comm'n, *supra* note 1, at 10, tbl. 1.

The Medicaid expansion significantly changes *who* is eligible for Medicaid, but the ACA does not change the basic structure of the program or *how* the program is implemented. Medicaid has always been a cooperative partnership between the federal government and the States, and the ACA does not change that. The Act continues the tradition of State flexibility and experimentation that has been the hallmark of cooperative federalism, by allowing the States to apply for federal grants, seek waivers, operate demonstration projects, and otherwise exercise discretion in implementing Medicaid. The ACA thus strikes an appropriate, and constitutional, balance between national requirements that will expand access to affordable healthcare and State flexibility to design programs that achieve that goal.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress created the Medicaid program more than 45 years ago as a way to help States provide healthcare to their neediest citizens. Under the program, participating States create and administer their own individual Medicaid plans, while acting within broad federal standards. All 50 states, the District of Columbia, and the U.S. Territories now participate in the program.

The ACA amends the Medicaid program, most notably by expanding eligibility for coverage, beginning January 1, 2014, to all non-elderly, non-Medicare-eligible adults whose incomes do not exceed 133% of the FPL. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). At issue here is whether Congress coerced the States when it

expanded Medicaid eligibility and gave the Secretary of the Department of Health and Human Services ("the Secretary") discretion to withhold Medicaid funding from States that fail to comply with the new eligibility requirements.

Amici—every bit as much as petitioners—are conscious of the threat posed to our liberty and our federalist system when Congress oversteps its authority. Amici thus understand the "gravity of the task of appropriately limiting the spending power." *South Dakota v. Dole*, 483 U.S. 203, 217 (1987) (O'Connor, J., dissenting). Amici remain vigilant in guarding against any Congressional attempt to strong-arm the States by abusing its spending authority. But Congress has not overstepped its authority or strong-armed the States in enacting the ACA's Medicaid expansion.

Requiring States to expand Medicaid eligibility to individuals whose income does not exceed 133% of the FPL is not coercive, nor is it an attack on the federalist system. In a cooperative federalist program, the federal government establishes the program's core requirements and gives the States the freedom to implement their own programs within those requirements. The Medicaid program has been popular and successful because it has adhered to that model. The ACA's Medicaid expansion does not change that fundamental arrangement, and it is entirely consistent with the history of the program. While expanding Medicaid's basic eligibility standards, the ACA does not disturb the States' autonomy and freedom to ex-

periment that has always been a hallmark of the program.

Over the last four decades, Congress has repeatedly required States choosing to participate in Medicaid to extend coverage to new populations in response to evolving policy concerns. That is consistent with the principles of cooperative federalism: Because Medicaid's eligibility standards are a core element of the program, the government permissibly may withhold Medicaid funds from States that fail to comply. By doing so, Congress is not coercing the States; it is simply defining the basic nature of the program. The same is true of the ACA's Medicaid expansion.

Historically, Congress has not acted alone in expanding Medicaid. The States have taken advantage of their freedom to experiment by extending eligibility to additional categories of the poor, beyond the mandatory coverage groups. After individual States have successfully expanded coverage, Congress often follows their lead by making expanded coverage mandatory. The ACA's Medicaid expansion follows the same pattern. The States have taken a leading role in developing the very innovations that Congress adopted in the ACA, including the eligibility expansion. Far from being an attack on federalism, the Medicaid expansion reflects a cooperative federalist program that is functioning just as it should.

The ACA also does not alter the fact that participation in Medicaid is voluntary. Congress structured the ACA and the timeline for its implementation in a way that makes it possible for States choosing to withdraw from Medicaid to do so. Although with-

drawing from the program may be difficult and politically unpopular, it remains an option.

Petitioners' facial challenge to the Medicaid expansion also fails because it rests on a false premise. Petitioners presume that Congress has required the States to implement the expansion or leave Medicaid. But that is not what Congress has done. To the contrary, Congress gave the Secretary *discretion* to determine an appropriate response—withholding some or all Medicaid funds—for States that do not implement the Medicaid expansion. Because the law expressly gives the Secretary that discretion, the law necessarily is capable of constitutional application and thus is not facially coercive.

ARGUMENT

I. Congress may not use its spending power to coerce the States into action, but it has broad authority to define the core standards of a cooperative federalist program.

Congress may use its spending power to persuade the States to pursue federal policy goals, but it may not go so far that its influence constitutes outright coercion. *Dole*, 483 U.S. at 211; *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937). That principle constrains Congress's power to attach conditions on federal funding, even for cooperative and voluntary programs like Medicaid. But at the same time, Congress has broad power to define the basic standards and policy objectives of such programs. Because of those competing principles, identifying the point at which federally imposed requirements become unconstitu-

tionally coercive is necessarily a fact-specific inquiry, and, as explained below, one that must involve a careful examination of the program as a whole.

The constitutional limits on Congress's spending power are crucial for State autonomy and for our system of divided sovereignty. *See Bond v. United States*, 131 S. Ct. 2355, 2366 (2011). If the spending power were unconstrained, then Congress could exercise it in ways that would undermine State authority and override local policy preferences. *See Davis v. Monroe County Bd. of Ed.*, 526 U.S. 629, 654-55 (1999) (Kennedy, J., dissenting) ("[T]he Spending Clause power, if wielded without concern for the federal balance, 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[.]"); *Dole*, 483 U.S. at 217 (O'Connor, J., dissenting) (arguing that spending power cannot be limited solely by "Congress'[s] notion of the general welfare"). For those reasons, the States are rightly "vigilant in policing the boundaries of federal power." *Davis*, 526 U.S. at 655 (Kennedy, J., dissenting).

Yet the States do not have an interest in advancing an unduly restricted vision of federal power. States often face obstacles to pursuing desired policies and favor federal action to remove those obstacles. For example, States may wish to make healthcare available to more people, but may fear that expanding their Medicaid program will inadvertently attract applicants from States that retain stricter standards, thereby overburdening the system.

Expansion of Medicaid at the national level provides a way to overcome that barrier to coverage. And Medicaid is just one example of many programs where the States and the federal government have "join[ed] in a cooperative endeavor to avert a common evil." *Steward*, 301 U.S. at 587. For amici, the crucial concern is that the limits on federal power must be sufficient to protect State authority while also preserving the benefits of cooperative federal-State programs.

For these reasons, the inquiry into whether Congress has overstepped its spending authority by changing the conditions for participating in a federal program is necessarily fact-specific, and must involve an examination of the program as a whole, including the purpose of the program, the types of conditions imposed, and the cost of noncompliance. *See Steward*, 301 U.S. at 590 ("[T]he location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree,—at times, perhaps, of fact."); *Dole*, 483 U.S. at 211 (holding that the federal funding at stake—approximately five percent of the State's federal highway funds—was "relatively mild encouragement," and thus the State's coercion argument was "more rhetoric than fact").

Congress has the most leeway when it is designing core elements of a federal program that are intended to carry out the federal policy objective. That is because Congress has the prerogative to expend federal funds consistently with its own view of the "general [w]elfare of the United States." U.S. Const. art. I, § 8, cl. 1. On the other hand, if Congress conditions receipt of a large amount of money on compliance with

an unrelated or attenuated requirement, or a relatively minor aspect of a program, the risk of coercion is significant and the Court's review should be searching. This Court's review should focus on the distinction between core elements of a federal program and tangential or minor requirements.

In analyzing a claim of coercion, this Court should also consider whether Congress has provided a meaningful role for the States to play. A Spending Clause program that required States to implement, without exception, a program designed by the federal government would raise questions about the constitutional balance between the State and federal governments. In contrast, a truly cooperative program that affords the States flexibility in its implementation is unlikely to be coercive.

II. The ACA's Medicaid expansion is not coercive.

A. The ACA continues Medicaid's longstanding model of cooperative federalism.

1. Medicaid remains a cooperative program that affords the States substantial flexibility and autonomy.

Since its inception, Medicaid has been a voluntary and cooperative program, under which "the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons." *Harris v. McRae*, 448 U.S. 297, 308 (1980). States that choose to participate must adhere to core requirements established by Congress but are given substantial flexibility to tailor their programs

as needed. The program "allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." *Hodel v. Virginia Surface Mining & Recl. Assn., Inc.*, 452 U.S. 264, 289 (1981).

The ACA does nothing to change that cooperative structure and, in fact, further promotes Medicaid's longstanding cooperative approach. As before, the States remain free to determine, within broad federal guidelines, the benefits that will be offered and how the program will operate. 42 U.S.C. § 1396a. And as before, the States can take advantage of Medicaid waiver programs to expand access to health insurance or test different approaches to providing care. *See* 42 U.S.C. § 1396n (providing various waiver programs); 42 U.S.C. § 1315 (permitting waiver of standard Medicaid requirements for "any experimental, pilot, or demonstration project" that, in the Secretary's discretion, "is likely to assist in promoting the objectives of" Medicaid).

And the ACA creates new ways for the States to innovate within Medicaid. For example, Oregon officials are already in the process of planning a health home program under section 2703 of the ACA, *see* 42 U.S.C. § 1396w-4 (codifying section 2703 of the ACA and allowing waiver for health home programs), to allow for better coordination and management of the health and long-term services provided to Medicaid recipients with multiple or severe chronic conditions. The Act also creates incentives for states to "rebalance" their Medicaid long-term care systems away

from institutional care to home and community-based settings, where appropriate. *See* 42 U.S.C. § 1396n(k). This provision was based on Washington's experience with such rebalancing. In addition, the ACA creates the Center for Medicare and Medicaid Innovation ("CMI"), which will "test innovative payment and service delivery models." 42 U.S.C. § 1315a. One way for CMI to do so is by "[a]llowing States to test and evaluate" different payment systems. 42 U.S.C. § 1315a(b)(2)(B)(x) & (xi).

In attempting to dispute the cooperative nature of the ACA, petitioners exaggerate the burdens that the Medicaid amendments impose. For example, the provisions setting minimum standards for Medicaid coverage do not place a "new and onerous requirement" on the States, Pet. Br. 8. Instead, the States retain the ability to determine the particulars of coverage, provided they work within minimum federal standards. *See* 42 U.S.C. § 1396a(k)(1); 42 U.S.C. § 1396u-7(b) (providing several options that qualify as "benchmark coverage" or "benchmark-equivalent coverage"). Petitioners correctly note that, beginning in 2014, Medicaid coverage must include certain "essential health benefits." 42 U.S.C. § 1396u-7(b)(5). But again, the "essential health benefits" requirement simply delineates general categories of coverage that must be offered, within which the States can tailor their Medicaid programs as needed. 42 U.S.C. § 18022(b). Indeed, recent guidance from the Department of Health and Human Services has emphasized that States have wide latitude in defining the essen-

tial health benefits based on each State's particular needs.[4]

The ACA also continues Medicaid's tradition of cooperative federalism by providing financial assistance to the States to implement the ACA's expansion. Indeed, the federal government will assume 100% of the cost of newly eligible Medicaid enrollees for the first three years of the expansion. 42 U.S.C. § 1396d(y). Although that percentage declines beginning in 2017, the federal government will continue to assume 90% of the cost in 2020 and beyond. *Id.* Even at 90%, the rate significantly exceeds typical federal Medicaid contribution rates, which range from 50% to 83%. *See* 42 U.S.C. § 1396d(b). Petitioners nonetheless complain at length about the supposed increase in State healthcare spending that the ACA will require. Pet. Br. 10, 16. But petitioners' argument is wrong for at least two reasons.

First, petitioners argue that, with the enactment of the ACA, State Medicaid spending will "increase by at least $20 billion" by 2020. Pet. Br. 10. But without measuring that number against the baseline of increased spending *without* the ACA, petitioners' assertion is meaningless. When compared to the baseline of what States would spend without healthcare reform, State spending is expected to increase by only

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[4] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (December 16, 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

1.4% under the ACA's eligibility expansion.[5] At the same time, the percentage of uninsured adults earning less than 133% of the FPL is expected to decrease nationwide by 44.5%.[6]

Second, petitioners complain about the "substantial costs generated by individuals who are *presently eligible for* but not enrolled in Medicaid," because those individuals will now enroll to comply with the minimum-coverage provision. Pet. Br. 16 (emphasis added). In essence, petitioners complain that their costs will increase because the ACA makes Medicaid more *effective* by encouraging and providing access to those who are *already* eligible. But those increased costs have nothing to do with the ACA's Medicaid expansion. Further, by focusing on the supposed costs of increased participation in Medicaid, petitioners ignore the cost savings created by the ACA. For example, increased coverage will lower the cost of uncompensated care, which is forecast to be between $106

[5] Kaiser Comm'n, *supra* note 1, at 10, tbl. 1.

[6] *Id.* Petitioners argue that other estimates show "that increased costs could be as high as . . . $43.2 billion for States." Pet. Br. 10. That estimate assumes an increase in enrollment by individuals currently eligible for Medicaid who have not yet enrolled. But even under that estimate, State spending would increase by only 2.9% over the baseline, with a 69.5% reduction in uninsured adults earning less than 133% of the FPL. Kaiser Comm'n, *supra* note 1, at 11, tbl. 2.

billion and $141 billion nationwide by 2019 without healthcare reform.[7]

2. The ACA's Medicaid expansion itself is the product of cooperative federalism.

Amici have taken full advantage of Medicaid's cooperative structure, working with the federal government to improve healthcare while crafting individualized programs that address each State's particular needs. One way that States have frequently taken advantage of the program's flexibility is by extending eligibility to additional categories of the poor, beyond the mandatory coverage groups. After individual States have successfully expanded coverage, Congress has often followed their lead by making that expanded coverage mandatory. In that way, the States' experiences shape and inform Congressional adjustments to the program's minimum federal standards.

For example, in 1965, the States could extend coverage to groups such as financially needy children who could not qualify for cash assistance. Health Insurance for the Aged Act, Pub. L. No. 89-97, § 1902, 79 Stat. 344 (1965). Two decades later, Congress amended Medicaid to make coverage of financially needy children mandatory. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388-166 (1990). Similarly, in 1986, Congress expanded the program to allow States the option to cover all pregnant women and infants with income below the FPL—whether they were receiving welfare

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[7] Garrett, *supra* note 2, at 13.

or not. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 2050 (1986). By 1988, that coverage became mandatory. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 750 (1988). Today, after decades of expansion, participating States are required to extend Medicaid to infants, children under age six, and pregnant women whose family incomes are below 133% of the FPL, as well as to all children 6 to 18 years of age with family incomes up to 100% of the FPL. 42 U.S.C. 1396a(a)(10)(A)(i)(IV), (VI)-(VII), (l)(1)-(2).

Thus, historically it has been the States, not Congress, that have led the way in expanding eligibility for Medicaid. Medicaid's flexibility has enabled the States to experiment with different approaches to healthcare policy and become the "laborator[ies]" of democracy once envisioned by Justice Brandeis. *See New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). When the States' experiments have demonstrated that extended coverage is effective and practical, then Congress has followed by "raising the floor" to make a wider group of needy people eligible. That is precisely how cooperative federalism should work: Congress first grants the States the flexibility to try alternative approaches, and then adjusts the federal minimum standards based on the States' experiences.

The ACA expansion follows the same pattern. Prior to the adoption of the ACA, a number of States attempted to address the alarming number of uninsured citizens and the lack of affordable insurance by

obtaining demonstration waivers and extending Medicaid coverage to low-income, nonelderly, nondisabled adults. For example, in 1997, Massachusetts implemented a Medicaid waiver to expand coverage to children with family incomes up to 200% of the FPL and certain categories of adults with incomes up to 133% of the FPL.[8] Similarly, Vermont expanded Medicaid eligibility to thousands of low-income residents with incomes as high as 185% of the FPL,[9] and to children with family incomes up to 300% of the FPL.[10] When Congress sought to address the national health coverage crisis by expanding coverage to all nonelderly Americans under 133% of the FPL, it was thus following the lead of States such as Massachusetts and Vermont. As with earlier expansions of eligibility, the

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[8] *See* Massachusetts Medicaid Policy Institute, *The MassHealth Waiver: 2009-2011...and Beyond* (Feb. 2009), *available at* http://www.massmedicaid.org/~/media/MMPI/Files/MassHealth%20Waiver%202009%20to%202011%20and%20Beyond.pdf

[9] Kaiser Comm'n on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences* 21 (July 2010), *available at* http://www.kff.org/medicaid/upload/8087.pdf

[10] Kaiser Comm'n on Medicaid and the Uninsured, *Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures* 23 (Oct. 2000), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13443

experiences of individual States helped to shape and inform new federal standards.

Amici have become leaders in healthcare reform by taking advantage of the flexibility in the current Medicaid system and by acting as models to promote changes within the national system. With the enactment of the ACA, amici intend to continue in that role, by both cooperating with the federal government and experimenting with new and individualized ways of improving access to healthcare.

B. Medicaid's eligibility standards are a core element of the program, and Congress may condition continued participation on compliance with those standards.

In changing Medicaid's eligibility standards, Congress made a considered policy choice to expand eligibility to a large population of formerly ineligible individuals and thereby help to lower the increasing number of uninsured Americans. Compliance with the new eligibility standards is thus necessary to carry out the basic goals of the program. For that reason, Congress may condition all Medicaid funding on compliance with those standards without running afoul of the Constitution. Rather than coercing the States into complying with a minor or tangential federal policy, Congress has defined one of the program's core elements.

Where a particular condition is a minor component of a massive program like Medicaid, and the condition is only peripherally related to the program's fundamental goals, threatening to pull *all* program

funds for failing to comply with that condition could effectively be coercive. If, for example, Congress conditioned all Medicaid funding on the requirement that a State prohibit physician-assisted suicide, that condition—though tangentially related to the provision of health care—would raise serious concerns. *Cf. Gonzalez v. Oregon,* 546 U.S. 243 (2006).

The converse is also true. If a federal requirement is crucial to effectuating one of Congress's central legislative policies, then it is appropriate for Congress to condition any further participation in the program on a State's compliance. Where noncompliance would frustrate a central policy of the program, a suspension of federal funds or termination from the program is commensurate with the breach. For example, a State would be hard-pressed to complain if the federal government conditioned all highway construction funding on compliance with minimum federal construction standards. In such an instance, Congress is not strong-arming the States; it is defining the basic nature of the program.

Central to the Medicaid program since its inception has been the requirement that, in exchange for federal funds, participating States must agree to extend Medicaid coverage to certain populations identified by Congress. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981) ("As originally enacted, Medicaid required participating States to provide medical assistance to 'categorically needy' individuals who received cash payments under one of four welfare programs established elsewhere in the Act."). The original 1965 Medicaid statute required participating

States to cover the elderly, disabled, and members of families with dependent children and an extremely low income. *Id.* In addition, Congress granted the Secretary the authority to withhold all Medicaid funds from participating States that failed to cover the required population groups or otherwise failed to meet program requirements. 42 U.S.C. § 1396c. Congress also reserved the right unilaterally to amend Medicaid at any time. 42 U.S.C. § 1304.

As described above, Congress has exercised its authority to amend Medicaid by expanding the mandatory coverage groups several times over the last 45 years, thus "raising the floor" of Medicaid. In these instances, Congress has required the States to comply with the expansion and has retained the Secretary's authority to withhold federal funds from participating States that fail to cover the required population groups. The ACA expansion continues the same pattern. Congress has once again redefined the program and "raised the floor" by extending mandatory eligibility.

Yet the ACA expansion is extraordinary in both size and purpose. Under the ACA, all Americans earning up to 133% of the FPL are eligible for Medicaid beginning in 2014. Under conservative estimates, there are expected to be approximately 15 million newly eligible Medicaid enrollees because of the ACA expansion.[11] In Oregon, for example, Medicaid

[11] Kaiser Comm'n, *supra* note 1, at 37, tbl. 3.

enrollment is projected to increase by 60% to 80% under the ACA.[12]

The ACA expansion also represents a major philosophical change in the purpose of the program. Since it was first enacted, Medicaid has been targeted narrowly to groups such as the elderly, the disabled, pregnant women, and children. In that way, the program was an extension of welfare programs that had historically been aimed at alleviating poverty among those perceived to have only a limited ability to fend for themselves. But under the ACA, Medicaid eligibility is extended to *all* Americans who are under 133% of the FPL, including single, childless, able-bodied adults. The expansion thus represents a new policy to address a new concern—namely, a pervasive lack of affordable health coverage.

Petitioners acknowledge that the Medicaid expansion is a "dramatic" change in the program. Pet. Br. 7. Indeed, it is precisely *because* the expansion represents such a significant change that petitioners apparently believe that the federal government cannot compel the States to comply with it. Pet. Br. 7-8, 34-35. But petitioners' reasoning turns cooperative federalism on its head.

Because the Medicaid expansion is crucial to effectuating one of the program's core policies, a State that refused to implement the expansion would frustrate one of the basic goals of the program. Withholding a noncomplying State's Medicaid funding in such

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[12] *Id.* at 10-11.

a circumstance is an appropriate, measured response, consistent with the principles of cooperative federalism and consistent with the federal government's role of setting the "significant requirements" of a cooperative program. *Schaffer v. Weast*, 546 U.S. 49, 52 (2005). Because the eligibility expansion is a fundamental shift in the program, Congress may permissibly require States to implement the expansion or leave Medicaid.

Petitioners also complain that, unlike some previous expansions, Congress did not give the States the option of continuing to participate in Medicaid while declining to undertake the expansion. Pet. Br. 10, 39-40. But there are sound policy reasons for Congress not to design the ACA expansion as an opt-in part of the program. First and foremost, the expansion is aimed at addressing a national crisis in the rate of the uninsured and a lack of affordable coverage. To address that problem and increase access to health insurance among the poor, Congress reasonably concluded that all States who want to remain in Medicaid must take part in the expansion.

In addition, by implementing a mandatory, uniform expansion, Congress allowed all participating States to address the problem of the uninsured simultaneously. If Congress made the expansion optional, even States that might favor the idea of expanding the program could potentially be dissuaded from doing so without assurance that other States would follow suit, for fear of putting themselves at an economic disadvantage. *See Steward*, 301 U.S. at 588 (explaining that the Social Security Act addressed the prob-

lem of States' unwillingness to create unemployment insurance for fear of putting themselves at economic disadvantage). By uniformly raising the floor of the Medicaid program for all participating States, Congress addressed this problem.

In objecting to the expansion, petitioners are effectively seeking to veto Congress's considered policy choice. When Congress makes a substantial change to the core of a popular program like Medicaid, participating States that are unhappy with the policy change may be forced to make a difficult choice. But the fact that the choice is difficult does not make it unconstitutional.

C. The gradual implementation of the expansion allows States wishing to opt out of Medicaid to do so.

Although withdrawing from a successful and popular program like Medicaid would be difficult, Congress has implemented the expansion in such a way to make it possible. By delaying implementation of the expansion, the ACA allows the States sufficient time to create and implement a replacement system—while continuing to receive federal funds. This lengthy transition period further supports the conclusion that the ACA's Medicaid expansion is not impermissibly coercive.

The eligibility expansion does not go into effect until 2014—nearly four years from the date the bill was signed into law. As a result, "states have plenty of notice . . . to decide whether they will continue to participate in Medicaid by adopting the expansions or

not." Pet. App. 62a. In addition, the federal government will fund 100% of the cost of expansion for the first three years. The States could therefore continue to participate in the program until 2017 without significant financial loss. Moreover, a State may also be able to continue to receive Medicaid funding while transitioning into a State-run program by proposing a demonstration project. If the Secretary determined that the project would serve the goals of the Medicaid program, the Secretary could waive some standard Medicaid requirements while continuing to provide federal funding. 42 U.S.C. § 1315(a). In sum, it would be feasible—although perhaps unpopular—for petitioners to opt out of Medicaid rather than comply with the eligibility requirements.

Petitioners misconstrue the ACA in arguing that States cannot give up Medicaid because it provides the only way for needy individuals to comply with the minimum-coverage provision. Nothing in the ACA provides that Medicaid is the only option for needy individuals. In fact, "minimum essential coverage" includes "[s]uch other health benefits coverage . . . as the Secretary of Health and Human Services, in coordination with the Secretary [of the Treasury], recognizes." 26 U.S.C. § 5000A(f)(1)(E). If a State were to withdraw from Medicaid and enact its own program for the needy, such a program could be recognized by the Secretary as providing minimum essential coverage.

In any event, the minimum-coverage provision will not affect most individuals who qualify for Medicaid, because the penalty provisions exempt those who are unable to afford coverage. 26 U.S.C. § 5000A(e).[13] Individuals making less than 133% of the federal poverty level[14] are unlikely to incur a penalty simply because their State chose to withdraw from the Medicaid program.

In sum, although withdrawal from the Medicaid program might be politically unpopular, it remains a viable option for States who do not wish to expand eligibility to individuals earning up to 133% of the federal poverty level. Congress has provided the States with adequate time to plan and implement a new system, as well as a mechanism for withdrawing from Medicaid in an orderly fashion.[15]

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[13] No penalty is imposed on individuals who are not required to file federal income tax returns for the year. 26 U.S.C. § 5000A(e)(2). Further, individuals are exempt from the penalty if their required insurance contributions exceed eight percent of their income or if the Secretary of Health and Human Services determines that they have "suffered a hardship with respect to the capability to obtain coverage under a qualified health plan." 26 U.S.C. § 5000A(e)(1), (5).

[14] The federal poverty level in 2010 was $10,830 for one person and $22,050 for a family of four. 75 Fed. Reg. 45,629 (Aug. 3, 2010).

[15] Petitioners contend that they cannot create a State-funded replacement for Medicaid, because the federal government is already taxing their citizens. Pet. Br. 42-46. But that argument evinces a fundamental misunderstand-

D. Petitioners' theory of coercion is unworkable and contravenes the purpose of federalism.

Petitioners have failed to advance a workable approach to coercion, one that is consistent with federalism and allows for reasonable, practical application both here and in future cases. In particular, petitioners fail to grapple with the consequences of their coercion theory, for Medicaid and for other critical federal-State programs that buttress State efforts to protect the health and welfare of their citizens.

Stripped to its essentials, petitioners' "coercion" argument is this: the funds available under the Medicaid program are so substantial, and the need for healthcare services for the poor so crucial, that no State can decline to participate in Medicaid. But petitioners' emphasis on Medicaid's size is misplaced. The coercion inquiry does not turn on the mere size or success of the federal program; instead, it is a fact-specific inquiry that looks to the design of the overall program and the relationship between the challenged condition, federal funding, and possible sanctions.

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ing of the Spending Clause power and our federalist system. In any case where the federal government exercises its Spending Clause power, a State that refuses to accept federal funds will lose out on money paid by its own citizens. If each State was instead given a different tax rate based on the amount of federal funds it received, we would no longer have a federalist system.

This Court has never suggested that Congress may tackle only small problems under the spending power, rather than large ones that require substantial funding. Nor would such a restriction be advisable. Federal action is often prompted by the kinds of collective action problems that the Court discussed in *Steward*. There, the States were hard-pressed to cope with massive unemployment caused by the nation's long depression. *See* 301 U.S. at 586 (describing unemployment as reaching "unprecedented heights"). Congress responded by providing an incentive for States to adopt unemployment insurance programs, by imposing an unemployment tax on most employers with a tax credit for employers who paid into approved state unemployment insurance programs. *Id.* at 574-75. The unemployment provisions of the Social Security Act were not a minor effort, but a major federal program intended to combat a serious national problem. The Court should not adopt a spending clause restriction that prevents Congress from designing programs that are large enough to be effective.

Likewise, the success of a program, as measured by the participation of the States, is not a basis for deeming the program coercive. This Court rejected that argument in *Dole*, 483 U.S. at 211, and petitioners' effort to resuscitate it here is unpersuasive. Petitioners may be correct that neither they nor the other States will decide to drop out of the Medicaid program in the coming years. But even if that proves true, it is because Medicaid is a valuable and popular program—not because the States are coerced into participating. As this Court held in *Dole,* a federal

grant program is not unconstitutional "simply by reason of its success in achieving the congressional objective." *Id.* at 211. Neither the universal participation of the States in Medicaid now, nor their likely participation in the coming years, proves that the program is unconstitutional.[16]

The ramifications of petitioners' theory of coercion would be far-reaching. One consequence of petitioners' argument is certain: if adopted, the Medicaid program will be effectively frozen in time and neither Congress nor the States will be able to adapt this successful, established program to help meet the future health care needs of more low-income Americans. Unmet health care needs, of course, are not static; those unmet needs will continue to grow as health care costs increase, the population ages, and demographic changes (such as the nation's obesity problem) prompt new demands on our national health

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[16] For the same reason, petitioners' reliance on the fact that Congress did not anticipate that any State would withdraw from Medicaid is misplaced. Petitioners' extensive discussion of the various provisions of the ACA demonstrates, at most, that Congress believed that the new eligibility expansion would not cause States to withdraw from Medicaid. *See* Pet. Br. 33-39. It would be entirely reasonable for Congress to assume that the States would choose to implement the federally funded expansion and continue participating in Medicaid, which has been successful, popular, and valuable to the States. Congressional recognition of the success of a federal program, much like the success of the program itself, does not render the program unconstitutional.

care system. Under petitioners' theory, however, Medicaid is just too big, and the States' dependency too "entrenched," Pet. Br. 42, for Congress to change the design of the program to meet those needs—even when such changes are democratically adopted and even when the changes are sought by most States.

The unintended consequences of petitioners' theory do not stop there. Every argument that petitioners advance here—the size of the Medicaid program, the States' dependence on federal funding, the need for the benefits and absence of any alternative program, the fact that State residents pay federal taxes that support Medicaid—could be made by a State threatened with termination of Medicaid funding for failure to comply with any of Medicaid's *current* requirements. Under petitioners' theory, in other words, the current Medicaid program should also be deemed unconstitutional. At the very least, petitioners' theory would prevent the federal government from enforcing any current Medicaid requirements.

Along with this uncertainty about the enforceability of current law, petitioners posit a future in which *any* changes to the program must be optional—taking away Congress's constitutional authority to "fix the terms on which it shall disburse federal money to the States." *See New York v. United States*, 505 U.S. 144, 158 (1992) (internal quotation marks omitted). And even that path may not be available to Congress, because according to petitioners, the offer of generous federal funding to support expansion of the program makes the program coercive. *See* Pet. Br. 47 ("the fact that the federal government's inducement is substan-

tial only exacerbates its coerciveness"). In petitioners' view, if Congress proposes a change and offers to fully fund that change, the offer is coercive. After all, if a State rejects the offer, its residents will still pay taxes to fund the change in other States. *See* Pet. Br. 44 (choice is "illusory" so long as State residents are paying federal taxes that fund programs in other States). In short, what petitioners seek is federal funding for Medicaid without meaningful federal constraints on the design of the program, where each State has individual veto power over the design of the "federal" program. But that result is not consistent with either federalism or—even more crucially—fundamental democratic principles.

Although petitioners oppose expanding Medicaid to cover more poor Americans, Congress made a different choice. Many States supported that choice, and advocated through the political process for more federal funding to expand Medicaid. The bargain struck is one that provides enormous benefits for the States: the federal government will cover nearly all the cost of health care for millions of Americans who cannot afford to pay for it on their own. That change will reduce the burden on States to pay for uncompensated health care and improve the health and well-being of their residents. At the same time, States retain flexibility in administering Medicaid and the option to seek waivers under the ACA to experiment with different approaches and respond to local needs. This is emphatically not a case where Congress has "tipped the scales of power" against the States. Pet. Br. 59. Rather, Congress carefully took the interests of the States into account and worked within Medicaid's es-

tablished and successful framework of cooperative federalism.

III. In any event, the Medicaid expansion is not facially coercive because the Secretary has the discretion to craft an appropriate response where a State fails to comply.

For the reasons explained above, Congress permissibly may expand Medicaid's mandatory eligibility groups and may withhold Medicaid funds from a State that refuses to implement the expansion. But even if Congress could not do so, it does not follow that the ACA's Medicaid expansion is facially unconstitutional. Congress has delegated to the Secretary the discretion to craft an appropriate response for States that do not implement the ACA's Medicaid expansion. Because of that discretion, the law is not facially coercive.

A party who mounts a facial challenge to a statute must demonstrate that the statute cannot operate constitutionally under any circumstance. *See United States v. Salerno*, 481 U.S. 739, 745 (1987) ("A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid."). Petitioners cannot carry that burden here.

Medicaid is a complex program with an extensive list of requirements for States that choose to participate. *See West Virginia v. U.S. Dept. Health and Human Serv.*, 289 F.3d 281, 294 (4th Cir. 2002) (noting that, given Medicaid's complexity, "there are untold

ways in which a state plan might fail to comply with the Act and the governing regulations"). To enforce those various requirements, Congress included an enforcement provision, 42 U.S.C. § 1396c. That provision, which has been a part of the law since its inception, authorizes the Secretary of the Department of Health and Human Services to withhold all *or some* of a participating State's Medicaid funds in the event that the State refuses or fails to comply with one of the Act's requirements:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, *in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure*), until the Secretary is satisfied that there will no longer be any such failure to comply. . . .

42 U.S.C. § 1396c (emphasis added).

Pursuant to that provision, if a State were to refuse to implement the Medicaid expansion, the Secretary would, after notice and a hearing, issue an order withholding some or all of the State's Medicaid funding unless and until the State came into compliance. Under the particular circumstances of a given case, the Secretary could decide to withhold all funds from a State that did not comply with the expansion. But Congress has not *required* the Secretary to do so. Instead, Congress has given the Secretary the discretion to determine the appropriate response for States that refuse to comply.

In arguing that the expansion is facially unconstitutional, petitioners *presume* that the Secretary would exercise her discretion by withholding all funds. That may or may not be true, but such a theoretical possibility is insufficient to sustain a facial challenge to the ACA. *Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 449-50 (2008) ("In determining whether a law is facially invalid, we must be careful not to go beyond the statute's facial requirements and speculate about 'hypothetical' or 'imaginary' cases."). To date, the Secretary has not notified any State that it will lose all Medicaid funds if it fails to comply with the Medicaid expansion. Accordingly, the issue whether the federal government may permissibly do so is not ripe for review.

As noted above, the Secretary could decide to withhold all funds from a State that did not comply with the expansion. But the mere fact that withholding all funds is included among the spectrum of choic-

es committed to the Secretary's discretion does not make the law facially coercive. *See West Virginia*, 289 F.3d at 292-93 (finding that Medicaid provisions were not facially coercive because of the possibility that the State could lose all Medicaid funds if it did not comply).

Medicaid is a complex law that imposes many requirements on States that choose to participate. Rather than attempt to provide a specific enforcement response for any particular breach, Congress made a reasonable—and constitutional—choice to leave this to the Secretary's discretion in the particular circumstances of a given case. Notably, the Secretary has always had discretion under 42 U.S.C. § 1396c to enforce *any* of the myriad conditions of Medicaid by withholding the noncompliant State's Medicaid funds. If the mere fact that the statute provides that the Secretary may withhold all Medicaid funds was enough to make the law unconstitutional, then the Medicaid Act is—and always has been—facially unconstitutional.

In short, this Court is not in a position to conclude that the Medicaid expansion is facially unconstitutional without knowing what the Secretary would do in a particular case. Because the law expressly delegates to the Secretary discretion to determine the appropriate course of action where States fail to implement the expansion, the law is necessarily capable of constitutional application.

CONCLUSION

The ACA's Medicaid expansion is not unconstitutionally coercive. This Court should affirm the judgment as to this issue.

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