No. 11-400

IN THE
Supreme Court of the United States

STATE OF FLORIDA, ET AL.,
Petitioners,
v.
UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, ET AL.,
Respondents.

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

BRIEF OF *AMICI CURIAE* INDIANA STATE LEGISLATORS, THE JAMES MADISON INSTITUTE, AND CHRISTOPHER CONOVER IN SUPPORT OF PETITIONERS (MEDICAID ISSUE)

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

FEDERAL STATUTES

CONSTITUTIONAL PROVISIONS

OTHER AUTHORITIES

INTEREST OF THE AMICI CURIAE[1]

Amici Curiae Indiana Legislators are state senators and representatives elected by the citizens of Indiana. The *amici* Legislators have a substantial interest in the validity of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Title I of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (collectively, "ACA" or "the Act"), particularly as related to the preservation of federalism and the integrity of state budgets.

The *amici* Members of the Indiana House of Representatives are as follows: Speaker Brian Bosma, and Representatives Ronald Bacon, James Baird, Robert Behning, Bruce Borders, Timothy Brown, Woody Burton, Roberty Cherry, Edward Clere, Suzanne Crouch, Wes Culver, Bill Davis, William Davis, Steve Davisson, Thomas Dermody, Sean Eberhart, Jeffrey Espich, Ralph Foley, William Friend, David Frizzell, Randy Frye, Douglas Gutwein, Robert Heaton, Kathy Heuer, Michael Karickhoff, Cindy Kirchhofer, Earl Allan Koch, Rebecca Kubacki, Donald Lehe, Matthew Lehman, Daniel Leonard, Kevin Mahan, Richard McClain, Jud McMillin, Wendy McNamara, Robert Morris, Timothy Neese, Cindy Noe, Rhonda Rhoads, Kathy Richardson, Milo Smith, Mike Speedy, Gregory

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[1] The parties have consented to the filing of this brief in letters of consent on file with the Clerk. No counsel for any party had any role in authoring this brief, and no one other than the *amici curiae* provided any monetary contribution to its preparation or submission.

Steuerwald, Jeffrey Thompson, Jerry Torr, Randy Truitt, P. Eric Turner, Matthew Ubelhor, Heath VanNatter, Timothy Wesco, David Wolkins, and David Yarde,

The *amici* Members of the Indiana Senate are as follows: President Pro Tempore David Long, and Senators Mike Delph, Brandt Hershman, Travis Holdman, Luke Kenley, Sue Landske, Connie Lawson, James Merritt Jr., Patricia Miller, and Brent Steele.

Amici Curiae The James Madison Institute was established in 1987 as a nonpartisan public policy center dedicated to advancing the principles of limited government, individual liberty, personal responsibility, and federalism within the original intent of the authors of the United States Constitution. The Institute's scholars have published numerous studies concerning the state of Florida's tax and budget policies, including several specifically dealing with the enormous impact of Medicaid upon the state budget. The current case centrally concerns the Institute because it represents an egregious violation of the concept of federalism as delineated in the Tenth Amendment.

Amici Curiae Christopher Conover, Ph.D., is a Research Scholar in the Center for Health Policy & Inequalities Research at Duke University and Mercatus Affiliated Senior Scholar. Dr. Conover has researched Medicaid and the medically indigent for many years.

SUMMARY OF ARGUMENT

Federalism is one of the cornerstones of our constitutional system. By reserving broad powers to the States and to the people, federalism protects liberty, enhances accountability, and fosters innovation. The Act, however, undermines the essence of federalism by denying States a meaningful choice on whether to expand their state Medicaid programs. States depend heavily on the hundreds of billions of dollars dispersed by the federal government through Medicaid. Because the federal government funds at least half of each State's Medicaid costs, no State could operate a comparable program without federal dollars, and no State could realistically decline to offer basic medical care to its neediest citizens. Nevertheless, the Act requires States to spend tens of billions of additional dollars to expand Medicaid coverage, and threatens States with the loss of all Medicaid funding unless they comply. Accordingly, the Act leaves States with no realistic choice but to continue to participate in Medicaid, in violation of the Tenth Amendment and the principles of federalism articulated in *South Dakota v. Dole*.

Moreover, because of Medicaid's size and the Act's all-or-nothing penalty provisions, the Act is uniquely suited for scrutiny under the coercion doctrine. Medicaid represents far and away the largest source of federal outlays to the States, and the largest component of spending by the States. The Act, in turn, requires States to spend tens of billions of additional dollars to expand coverage, on penalty of losing every last dollar of federal Medicaid support.

These and other provisions suggest that Congress designed the Act to preclude the States from exercising a meaningful choice. For these reasons, if the coercion doctrine is *ever* to have any role in protecting the principles of constitutional federalism, the Act must be deemed invalid.

ARGUMENT

I. THE ACA LEAVES STATES WITH NO REALISTIC ABILITY TO OPT OUT OF MEDICAID.

A. States Are Dependent on Federal Medicaid Dollars.

Established in 1965, Medicaid is a cooperative federal-state partnership designed to provide medical assistance for specific categories of needy individuals. *Harris v. McRae*, 448 U.S. 297, 301 (1980); *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). As originally designed, Medicaid was to be partially funded by the States, with federal funding covering at least half of each State's costs. *See* 42 U.S.C. § 1396d(b).

By any measure, Medicaid represents the largest category of federal outlays to the States. In absolute dollars, the federal government is projected to spend nearly $4.4 trillion on Medicaid over the next ten years, which represents approximately 9% of all federal spending. *See* Office of Mgmt. & Budget, Exec. Office of the President, *Budget of the United States Government, Fiscal Year 2012*, at 174 (2011). In fiscal year 2010, the federal government distributed more than $233 billion for Medicaid to

the States. Nat'l Ass'n of State Budget Officers, *2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending*, at 47 (2011) (hereinafter NASBO Report). Today, nearly one in five Americans receives some assistance through Medicaid. *See id.* at 44 (noting that Medicaid "provides comprehensive and long-term medical care for more than 60 million low-income individuals").

Medicaid dwarfs all other federal outlays to the States. In 2010, the federal government directed more than $552 billion in federal funds to the States. NASBO Report at 7. Fully 42.3 percent of this spending went for Medicaid. *Id.* at 9. By way of comparison, the next largest categories of state spending from federal funds are elementary and secondary education, which are mostly funded at the state and local levels, at 12.7 percent, and transportation, at 7.2 percent. *Id.* In other words, the federal government gives the States more than three times as much money for Medicaid as for the next largest category of programs, and twice as much for Medicaid as the next two largest program categories combined. Medicaid is the 900-billion-pound gorilla of federal intergovernmental transfers.

These federal dollars are the life blood of the States' Medicaid programs. Federal funds cover anywhere from 50 to 83 percent of each State's Medicaid costs. 42 U.S.C. § 1396d(b). In 2010, most States received more than $1 billion in federal Medicaid funding, and a quarter of States received more than $5 billion. *See* NASBO Report at 47. Without federal funding, state Medicaid programs could not operate as currently constituted and funded.

Even with these federal dollars, States already spend a larger percentage of their budgets on Medicaid than on any other item. In fiscal year 2011, Medicaid accounted for about 22.3 percent of total state spending. *Id.* at 5. In comparison, States spent approximately 20.5 percent of their budgets on elementary and secondary education, 10.2 percent on higher education, and 7.7 percent on transportation. *Id.* Because Medicaid already consumes the single largest percentage of total state spending, any significant mandatory increase would drastically upset state budgetary priorities.

B. The ACA Compels States to Spend Billions of Additional Dollars on Medicaid.

Notwithstanding Medicaid's current costs, the ACA requires that States spend tens of billions of additional dollars over the next decade and beyond. Pursuant to the ACA, States must enroll millions of additional people in Medicaid and bear a range of administrative costs. Although the federal government covers a high percentage of the costs of new enrollees, the sheer size of Medicaid still leaves the States holding a very expensive bag.

According to numerous studies, the ACA will cost States $20-40 billion over the short term and up to $120 billion over the next decade, despite the federal government's increased contributions. The non-partisan Congressional Budget Office (CBO) has estimated new state spending on Medicaid at $20 billion between 2010 and 2019. True Cost of PPACA: Effects on the Budget and Jobs Hearing Before the H. Subcomm. on Health of the H. Comm. on Energy

& Commerce, 112th Cong. (March 30, 2011) (written testimony of CBO Director Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 at 24) (hereinafter CBO Report). An independent report from the Kaiser Commission estimates new state spending at $43.2 billion through 2019. Randall R. Bovbjerg et al., Kaiser Commission on Medicaid and the Uninsured, State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts 4 n.27 (Feb. 2011) (hereinafter Kaiser Report).

After 2019, state spending will increase at a faster rate. The CBO estimates new state spending at $60 billion through 2021. CBO Report, *supra*, at 24. Another congressional report comprehensively examined state government estimates, which States use to manage their own budgets. *See* S. Fin. Comm. & H. Energy & Commerce Comm., 112th Cong., *Medicaid Expansion in the New Health Law: Costs To The States* (hereinafter Joint Committee Report). This report "conservatively estimates that PPACA will cost state taxpayers *at least* $118.04 billion through 2023." *Id.* at 2 (emphasis in original).[2]

These additional costs stem largely from new enrollees in Medicaid. Prior to enactment of the ACA, Medicaid allowed States substantial

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[2] The cost estimates vary because they encompass different time periods and rely on different assumptions. For example, some studies ignore the costs of administration. Other studies apply different methodologies to estimate the number of new enrollees or potential to reduce the costs of uncompensated care. *See generally* Kaiser Report, *supra*.

discretion in determining eligibility based on federal poverty levels. Beginning in 2014, however, the ACA requires state Medicaid programs to cover non-pregnant, non-elderly individuals with incomes up to 133 percent of the federal poverty level. NASBO Report, *supra*, at 44. In most places, States will have to provide Medicaid to adults without dependent children for the first time ever, and also will have to increase the income eligibility level for parents. As a result, States will have to enroll 15 to 20 million additional people in their Medicaid systems. Mitch Daniels, *An ObamaCare Appeal From the States*, Wall St. J., Feb. 7, 2011 (hereinafter Daniels). Through 2016, the federal government will fully fund this requirement, but by 2020 and thereafter, it will cover only 90 percent of these costs, thereby leading to even higher state costs over the long term. NASBO Report, *supra*, at 44.

The ACA also leaves the States to bear significant administrative costs. According to one analysis, the ACA's administrative costs will approach $12 billion total between fiscal years 2014 and 2020. Edmund F. Haislmaier & Brian C. Blasé, The Heritage Foundation, *Obamacare: Impact on States*, in Backgrounder No. 2433 (July 1, 2010) (hereinafter Haislmaier & Blasé). Among other administrative tasks, States must create new systems to simplify and coordinate eligibility and enrollment for Medicaid. *See* Kaiser Report, *supra*, at vi (noting that administrative costs typically range from five to eight percent of all new spending). States also must use their "current welfare apparatuses to do the numbingly complex work of figuring out who is eligible for its subsidies, how much each person or

family is eligible for, redetermining this eligibility regularly, and more." Daniels, *supra.*

Finally, States will incur a variety of other costs. For example, the ACA changes the drug rebate allocation between the federal government and the States. Due to this change, Florida expects to lose $40 million in rebates in fiscal year 2010-2011. Joint App. on Medicaid at 76. Nebraska estimates a total loss of between $68.1 and $74.4 million for fiscal years 2011 through 2020, *id.* at 149, and Texas expects to lose $70.4 million in rebate revenue from 2010 to 2013, *id.* at 190. States also may have to pay higher physician fees after 2014. *See* Kaiser Report, *supra*, at vi (discussing cost categories).

These new costs will dramatically reshape state budgets. According to one study, the increased expenditures, particularly on long-term care, will cause the percentage of state operating budgets devoted to Medicaid nearly to double by 2030. Deloitte Center for Health Solutions, *Medicaid Long-term Care: The Ticking Time Bomb* at 5 (2010). In New York, Medicaid expenses could consume nearly 40 percent of the state budget by 2030. *Id.*

Similarly, in a relatively poorer state such as Mississippi, the ACA will cause Medicaid to swallow the State's budget. According to a study commissioned by the State, the ACA's average yearly impact on the budget will range from $86 million to $166 million, depending on the actual number of new enrollees. Lanhee J. Chen, The Heritage Foundation, *How Obamacare Burdens Already Strained State Budgets* 4-5, Backgrounder No. 2489 (Nov. 10, 2010). Using the study's "moderate participation" scenario,

the ACA will add about $126 million in average yearly spending to Mississippi's budget between 2011 and 2020. *Id.* at 5. This amount of spending far exceeds the amount the State will spend on its public safety, military, and veterans affairs agencies combined. *Id.* Moreover, the average yearly cost of the Act's Medicaid expansion far exceeds what the State spends on vocational and technical education, and represents more than four times the amount spent on student financial aid at the State's institutions of higher learning. *Id.*

The new requirements could force some States to spend *billions* of extra dollars a year. California, for example, will spend at least another $19.4 billion on Medicaid, leading former Governor Schwarzenegger to call the ACA "a disaster for California." Joint Committee Report, *supra*, at 2. Texas estimates that, starting in 2014, it will have to spend an extra $27 billion over ten years—"more than the program's entire annual budget today." *Id.* The new requirements will particularly affect Texas, Nevada, and Oregon, three states whose Medicaid populations are expected to grow by fifty percent or more because of the ACA. Chen, *supra*, at 3. Numerous other States paint fiscal pictures that are equally bleak. *See, e.g.*, Joint App. on Medicaid 116 ¶ 5 (Arizona anticipates additional spending of between $7.5 and $11.6 billion over ten years); 135 ¶ 4 (Louisiana anticipates losing $7 billion in federal matching funds over thirteen years).[3]

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[3] As economist Dr. Chris Conover explains, "ACA is essentially forcing states to swallow an increase in their Medicaid burden that will be about one fifth larger than it

For smaller States, the ACA could puncture their already fragile budgets. Idaho determined that the law would grow its Medicaid program by nearly fifty percent. Joint Committee Report, *supra*, at 2. *See also* Kaiser Report, *supra* (discussing various cost estimates). In Indiana, independent actuaries have pegged the price to state taxpayers at $2.6 billion to $3 billion over the next ten years. Daniels, *supra*. According to Indiana Governor Mitch Daniels, "This is a huge burden for our state, and yet another incremental expenditure the law's authors declined to account for truthfully." *Id*.

C. States Have No Meaningful Choice Except to Comply with the ACA.

To incent the States to remain in Medicaid, the ACA takes an unprecedented step: it conditions a State's continued receipt of *all* federal Medicaid funds on its acquiescence to the massive changes brought about by the ACA. Rather than simply withhold *additional* funding should States decline to expand coverage, Congress has threatened to

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would have been under the status quo (i.e., 8.2 percentage points above the 44.7 percentage point increase states would have expected to accept under the current rules of the road). Here the consequences of rejecting Medicaid become more stark: this burden would increase *247 percent* for the average state electing not to accept the conditions laid out in ACA. Perhaps the analogy is a bad one, but in my non-lawyer's view of the world, this is roughly equivalent to the neighborhood kid asking for a $20 'donation' by threatening to inflict $250 damage on your property if you decline. Is such a donation voluntary or coerced?" Conover, *Medicaid Coercion--In Your Heart You Know the States are Right: Healthcare Fact of the Week* (2012) (emphasis in original) (hereinafter Conover).

withhold *all* Medicaid funding if States reject the Act's terms. *See* Julie Stone et al., Cong. Research Serv., *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA,* at 2 (Apr. 28, 2010) (stating that "the law requires states to expand Medicaid"). In other words, the Act gives a State an all-or-nothing choice: accept the Act's terms, expand coverage, and spend billions of extra dollars, or forfeit the largest source of federal outlays to the States, approximately one to five billion dollars per State, per year, and shoulder the Herculean task of providing health coverage for the indigent solely from state revenues. Thus, the Act "incents" States to expand Medicare coverage with a stick the size of a Sequoia.

Indeed, the Act assumes that no State would or could opt out of Medicaid. The ACA imposes an individual mandate that requires all individuals to obtain health insurance, *see* ACA § 1501(b), and provides subsidies for individuals with incomes from 100-400% of the federal poverty line, *see* ACA § 1401(a). Perhaps counter-intuitively, however, the ACA does not provide subsidies to individuals with income under 100% of the poverty line; instead, it conclusively presumes they will have a state Medicaid program to join. In analyzing the Act's budgetary impact, a Nevada agency explained how these anomalous subsidy provisions expose Congress's true intent:

> It is clear from both the Senate and House health reform bills that Congress did envision the possibility of states reducing Medicaid coverage and spending. Both bills try to

> forestall such state action by mandating that states maintain eligibility in the program, and both bills try to sweeten the deal by adding additional federal Medicaid funding for some aspects of the proposed expansion. However, *Congress did not appear to envision a scenario where a state or states chose to act in their financial best interest by opting out of Medicaid*. This is evidenced by the lack of credits and subsidies in both bills for citizens who would otherwise qualify for Medicaid.

Nevada Dep't of Health and Human Servs. & the Div. of Health Care Financing and Policy, Medicaid Opt Out White Paper at 18 (Jan. 22, 2010) (emphasis added) (hereinafter Nevada Report).

Accordingly, a State has a "choice" of whether to comply with the ACA in only the strictest, most formalistic sense of the word. In theory, a State could opt out of Medicaid, lose billions of dollars of federal support, and watch its citizens' tax dollars flow to the Medicaid programs of other States. The State then could, again in theory, either raise taxes on its citizens by one to five billion dollars annually to compensate for the loss of federal funds, cut other spending to the marrow, or leave roughly one-fifth of its poorest citizens and children without basic medical care (or some combination thereof). As this description suggests, any purported "choice" amounts to nothing more than a cruel fiction.

States cannot realistically raise taxes enough to compensate for the loss of federal Medicaid funds. To maintain their programs at pre-ACA levels,

States would need to raise taxes by an average of 39.7 percent in 2013. Edmund F. Haislmaier, The Heritage Foundation, *Quantifying Costs to States of Noncompliance with the PPACA's Medicaid Expansion* at 4 (Jan. 12, 2012). While a 40 percent tax hike may sound unpalatable (and unrealistic), many States would have to raise taxes even higher. *Id.* at 3. To cover a loss of federal Medicaid funding, Alabama would need to increase its projected $7.5 billion in general-fund revenues by another $4 billion, or 53 percent. *Id.* Arizona and Louisiana would have to increase general-fund revenues by more than 60 percent, while Mississippi and Missouri would have raise taxes by more than 70 percent. *Id.* Due to the economic and budgetary situation in Michigan, that State would have to raise revenues by *more than 88%* to compensate for a loss of federal Medicaid funds. *Id.*[4]

In addition to the sheer magnitude of the higher state tax burden, the ongoing federal tax burden further constrains any State that might consider raising state taxes to compensate for the loss of federal funds. The ACA does not provide a State with a rebate, or partial rebate, of its citizens' tax dollars if the State chooses to opt out of Medicaid.

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[4] As Dr. Conover explains, a State would almost quadruple the state tax burden on its citizens by opting out of Medicaid and maintaining a comparable program on its own: "the average state collected $477 per capita to pay for the state share of Medicaid. Under the status quo, that will grow to nearly $930 by 2019, a 95 percent increase; under the ACA, it will more than double. But what happens to the average state electing to reject ACA? State Medicaid revenues per resident will balloon by 371 percent." Conover, *supra*.

See, e.g., Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195, 213-14 (2001) ("[S]hould a state decline proffered federal funds because it finds a condition intolerable, it receives no rebate of any tax dollars that its residents have paid into the federal fisc. In these cases, the state (through its residents) contributes a proportional share of federal revenue only to receive less than a proportional share of federal spending."). Therefore, if a State opted out of Medicaid, its citizens would continue to have to pay the same amount of taxes to support the federal Medicaid program, in addition to paying new, higher state taxes to support the State's independent medical program. No State would or could "choose" to forfeit one to five billion dollars annually of its citizens' tax dollars to Washington, D.C., and to other States, and then raise taxes on its citizens by an equivalent amount. Perhaps for some programs, such as a few million dollars in highway funds, the States and their taxpayers might willingly pay higher state taxes, as well as federal taxes, to avoid unpalatable federal mandates. As the largest single source of federal outlays to the States, Medicaid is not one of those programs. Medicaid's magnitude matters.

Furthermore, given the size of Medicaid's disbursements, States cannot realistically cut other spending enough to compensate for the loss of federal dollars. In many States, of course, budgets are already very lean due to ongoing economic maladies. If a State chose to opt out of Medicaid, it would have to double, triple, or even quadruple its own Medicaid spending to provide a similar level of pre-ACA medical care. Connecticut, a wealthy state that

receives the minimum federal Medicaid contribution of 50 percent, would still have to double state Medicaid spending to replace the half currently paid by the federal government. *See* Haislmeier, *supra*, at 4. In Mississippi, which receives a federal Medicaid contribution of 75 percent, the state government would have to *quadruple* state Medicaid spending to replace the three-quarters share currently paid by the federal government. *Id.* Such increases would necessarily crowd out other critical spending in the next largest categories of state spending, including education, transportation, and public safety. *See id.*

Finally, States cannot plausibly terminate medical support for their neediest citizens. As this Court has recognized, "a complete withdrawal of the federal prop in the system . . . could seriously cripple a state's attempts to provide other necessary medical services" to its residents. *Harris v. McRae*, 448 U.S. 297, 309 n.12 (1980) (quoting *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 132 (1st Cir. 1979)). According to the National Association of State Budget Officers, while state general fund spending is expected to grow slowly over the next few years, spending on Medicaid will continue to show above average growth as a result of increased demand driven by the economic downturn and other factors. NASBO Report, *supra*, at 3.

If, hypothetically, a State did opt out of Medicaid, the impact on its residents would border on the unthinkable, if not the inhumane. In Nevada, for example, the "Nevada Safety Net for Health would provide continued medical assistance to the most vulnerable," but "as many as 200,000" Medicaid-eligible Nevadans "will not be able to obtain or afford

coverage through the proposed Health Insurance Exchanges, and will merely add to the numbers of uninsured" and "increase the cost burden to providers, state and local governments to serve the poor." What is more, "another 40,000 Nevada seniors will not receive the supplemental benefits to Medicare they currently receive from Medicaid." Nevada Report at 23. These uninsured, ineligible individuals "would lose access to prenatal care, inpatient and outpatient hospital services, professional medical care, pharmaceuticals, infant and child preventive care, behavioral health care, dialysis, and Medicaid hospice care." *Id.* at 20. No State would voluntarily "choose" to inflict such pain on its citizens.

Furthermore, even if a State was inclined to opt out of Medicaid, the State would still have to comply with other costly aspects of federal law, without the benefit of federal Medicaid dollars. For example, federal law requires certain levels of coverage for some quickly growing cost items, such as care at nursing facilities. *See* Ctrs. for Medicare & Medicaid Servs., Your Guide to Choosing a Nursing Home 18 (noting that "[f]ederal law requires all Medicare and/or Medicaid-certified nursing homes provide enough staff to provide care for each resident based on their needs"). Similarly, federal law requires providers to care for patients under some circumstances even if those patients cannot pay for the medical services. *E.g.*, 42 U.S.C. § 1395dd.

For these reasons, the Act stands in a class by itself in terms of its ability to cast a State into an immediate and insoluble budget crisis. An opt-out State would lose more than incremental federal

funding. It would lose all federal funding for a program necessary to provide immediate, life-or-death care to a substantial bloc of its citizens.

D. The ACA Unconstitutionally Coerces States into Remaining in Medicaid.

As this Court has explained, Congress may not coerce States with terms so onerous as to eliminate their freedom to decide whether to participate in a federal program. *New York v. United States*, 505 U.S. 144, 166 (1992). "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.'" *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

These guidelines protect the integrity of state finances and the political accountability of the nation's federalist system of government. Federal coercion may threaten States' financial integrity, create "staggering burdens," and give the federal government "leverage over the States that is not contemplated by our constitutional design." *Alden v. Maine*, 527 U.S. 706, 750 (1999). "The potential national power would pose a severe and notorious danger to the States and their resources." *Id.* Moreover, "[b]y forcing state governments to absorb the financial burden of implementing a federal regulatory program, Members of Congress can take credit for 'solving' problems without having to ask their constituents to pay for the solutions with higher federal taxes." *Printz v. United States*, 521 U.S. 898, 930 (1997).

In evaluating whether Congress has coerced a State, or allowed the State to exercise a meaningful choice, this Court has adopted a functional analysis, rather than a purely formalistic analysis. In *Steward Machine*, for example, this Court rejected a coercion claim only after finding that a State could make a choice "of her unfettered will, [and not] under the strain of a persuasion equivalent to undue influence[.]" 301 U.S. at 590. "[T]he point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact." *Id.*; *cf. Frost v. R.R. Comm'n of State of Cal.*, 271 U.S. 583, 593 (1926) ("no choice" exists where the alternatives are "to forego a privilege which may be vital to [one's] livelihood or submit to a requirement which may constitute an intolerable burden"); *Lee v. Weisman*, 505 U.S. 577, 595 (1992) ("Law reaches past formalism. And to say a teenage student has a real choice not to attend her high school graduation is formalistic in the extreme").[5]

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[5] In *Citizens United v. Fed. Election Comm'n*, 130 S.Ct. 876, 892-896 (2010), this Court decided to address the facial validity of a provision of federal campaign finance law. Among its reasons, the Court cited "the primary importance of speech itself to the integrity of the election process." *Id.* at 895. In this vein, the opinion noted that the regulatory scheme might not be a prior restraint on speech in the strictest sense of that term, but analyzed the scheme based on its practical consequences: "As a practical matter . . . [the] restrictions . . . function as the equivalent of prior restraint by giving the FEC power analogous to licensing laws implemented in 16th- and 17th-century England, laws and governmental practices of the sort that the First Amendment was drawn to prohibit." *Id.* at 895-96. Like freedom of political speech, federalism is a cornerstone of the Constitution. *See, e.g., U.S. Term Limits, Inc. v. Thornton*, 514

The line between influence and coercion depends, in part, on the magnitude of the harm. In *Dole*, for example, the Court considered the State's argument "more rhetoric than fact" because the stakes were so low: the price of refusing federal prescriptions was only five percent of certain highway-related grant funds. 483 U.S. at 211.

On the other hand, the coercion doctrine should apply where Congress adopts an all-or-nothing strategy with enormous federal funding consequences. In *College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board*, 527 U.S. 666, 687 (1999), all nine Justices acknowledged the coercion doctrine in a case that closely divided on the question of whether a federal act unlawfully could "coerc[e]" a State to waive its sovereign immunity as a condition of pursuing lawful activity. The majority approvingly quoted *Dole*'s "financial inducement" coercion standard. *Id.* In a dissenting opinion, Justice Breyer, joined by three other Justices, discussed the coercive effect of compelling a State to forgo federal funds. *Id.* at 693-705. The dissent suggested that it may be "compelling or oppressive" for Congress to condition substantial funding sent to States annually, such as for highways ($20 billion in 1998), or especially, for education ($21 billion in 1998). *Id.* at 697. *See also United States v. Butler*, 297 U.S. 1, 71 (1936)

U.S. 779, 838 (1995) (Kennedy, J., concurring) ("It was the genius of [federalism] that our citizens would have two political capacities, one state and one federal, each protected from incursion by the other."). Federalism's importance provides an additional reason for evaluating the coerciveness of the Act's Medicaid provisions based on its practical effects.

(holding that coercion occurs where a refusal to accept benefits may result in "financial ruin").

Here, the Act pressures the States past "the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach.*, 301 U.S. at 590). Because Medicaid represents far-and-away the largest source of federal disbursements to the States, and the largest single category of spending by the States, the Act dwarfs the "mild encouragement" upheld in *Dole*. *Id.* "[W]hat Congress threatens if the State refuses to agree to its [ACA] condition is not the denial of a gift or gratuity, but a sanction" in violation of State sovereignty and the Constitution's federalism principles. *See Florida Prepaid*, 527 U.S. at 687.

An analogy to the law of contracts further demonstrates the coercive nature of the ACA. Federal spending legislation "is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). When Congress conditions acceptance of federal funds upon adoption of a federal regulatory program, the legality of Congress's action "rests on whether the State voluntarily and knowingly accepts the terms" Congress has attached to the funds. *Id.* The federal government may not "surpris[e] participating States with post acceptance or 'retroactive' conditions." *Id.* at 25.

In contract law, courts have long recognized that a party "coerces" a promise from another party by attempting to renegotiate a contract on which the other party has reasonably relied. *See, e.g.*, *Alaska*

Packers' Ass'n v. Domenico, 117 F. 99, 100-02 (9th Cir. 1902) (holding that sailors impermissibly coerced a promise of higher wages by refusing to fully perform a contract after the owner had lost the ability to find other sailors); *see also* Brief for James F. Blumstein as Amicus Curiae in Support of Cross-Appellants the State of Florida, et al. at 8-17, *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011) (No. 11-11067) (explaining how the ACA impermissibly modifies the contract between the federal government and the States). Over the past half-century, the States have come to depend upon federal Medicaid dollars. They should not have to "choose" between accepting burdensome new conditions, or losing all of the benefits of the original contract, when they have no other realistic option.

Similarly, courts have recognized that an entity with monopoly power can coerce market participants by illegally leveraging or "tying" the sale of one product to the purchase of another product. *LePage's Inc. v. 3M*, 324 F.3d 141, 154-57 (3d Cir. 2003) (en banc) (reasoning that the threat of lost rebates could coerce buyers into purchasing tape only from the monopolist); *SmithKline Corp. v. Eli Lilly & Co.*, 575 F.2d 1056, 1065 (3d Cir. 1978) (holding that coercion occurs where the buyer was effectively "force[d]" to purchase the tied product). With the ACA, Congress, which exercises monopoly power over the federal fisc, has impermissibly threatened States with the loss of *all* federal Medicaid funds unless they agree to expand coverage by adhering to the ACA. Given the size and scope of Medicaid, States are locked into compliance with the Act's terms, regardless of the

additional costs. As a matter of both contract law and constitutional law, Congress's actions impermissibly coerce the States into accepting the terms of the ACA.

II. THE ACA IS UNIQUELY SUITED FOR SCRUTINY UNDER THE COERCION DOCTRINE.

The coercion doctrine helps to protect the liberty of individual Americans. "The Constitution does not protect the sovereignty of states for the benefit of the States or state governments as abstract political entities, or even for the benefit of the public officials governing the States. To the contrary, the Constitution divides authority between federal and state governments for the protection of individuals." *New York v. United States*, 505 U.S. 144, 181 (1992). When one level engages in excesses, the other level of government serves as a channel for renewed expressions of self-government. This careful balance enhances the express protections of civil liberties within the Constitution.

If there ever was a law that cried out for scrutiny under the coercion doctrine, it is the Affordable Care Act. Although this Court has never invalidated a law pursuant to the coercion doctrine, there are multiple factors that place the ACA in a league of its own: (1) the magnitude of Medicaid, which represents by far the largest category of federal outlays to the States, and the largest category of spending by the States; (2) the size of the Act's financial impact on the States, which requires them to increase Medicaid spending by tens of billions of dollars; (3) the Act's all-or-nothing penalty

provisions, which threaten States with the loss of *all* Medicaid funds, not just funds associated with the Act's new requirements; (4) the practical and political impossibility of forgoing federal Medicaid funds, which benefit citizens in a more immediate, critical manner than even education or transportation funds; (5) the existence of federal minimum care requirements that severely constrict a State's ability to dispense care without Medicaid dollars; and (6) Congress's assumption, as reflected within the Act itself, that no State could or would opt out of its provisions.

Due to the combination of these factors, the Court need not determine a precise line at which influence turns into unconstitutional coercion. Each of these factors provides a basis for distinguishing the Act from routine, run-of-the-mill spending decisions by Congress. While there is doubtless a line at which influence turns into duress, and while that line lies somewhere between the few millions at issue in *Dole* and the $120 billion at issue here, the ACA, more than any other statute in history, clearly falls on the coercion side of the line.

CONCLUSION

For these reasons, States have no meaningful choice other than to comply with the ACA. Accordingly, the ACA is invalid under the Tenth Amendment and the principles of federalism articulated in *South Dakota v. Dole*.

Respectfully submitted,

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