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No. 11-400

IN THE
Supreme Court of the United States

STATE OF FLORIDA, *et al*.
Petitioners,
v.
U.S. DEPT. OF HEALTH & HUMAN SERVICES, *et al*.,
Respondent.

On Writ of Certiorari to the U.S. Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* SUBMITTED ON BEHALF OF FAITHFUL REFORM IN HEALTH CARE AND THE WISC HEALTH CARE WORKING GROUP IN SUPPORT OF RESPONDENT'S POSITION ON MEDICAID

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STATEMENTS OF INTEREST OF *AMICI CURIAE*[1]

This brief is submitted on behalf of diverse religious organizations[2] to inform the Court about the

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[1] Counsel for the parties filed blanket consents to *amicus* briefs in this case. Counsel for *amici* timely notified counsel of record of its intent to file this brief. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici*'s counsel, contributed money intended to fund preparation or submission of this brief.

[2] *Amici* are: American Baptist Home Mission Society; American Muslim Health Professionals; Association of Professional Chaplains; Buddhist Peace Fellowship; Central Conference of American Rabbis; Disciples Home Missions, Christian Church (Disciples of Christ) in the United States and Canada; Disciples Justice Action Network; Church of the Brethren; Everence Financial (formerly Mennonite Mutual Aid); Face to Face International Outreach Ministries; Faithful Reform in Health Care; Global Justice Institute; Interfaith Center on Corporate Responsibility; Islamic Medical Association of North America; Jewish Reconstructionist Federation; Mennonite Central Committee U.S. Washington Office; Mennonite Healthcare Fellowship; Metropolitan Community Churches; The Fellowship of Affirming Churches; The General Synod of the United Church of Christ; Union for Reform Judaism; Unitarian Universalist Association; United Methodist Church – General Board of Church and Society; Washington Interreligious Staff Community Health Care Working Group; Reverend Gradye Parsons, Stated Clerk of the General Assembly, Presbyterian Church (U.S.A), on behalf of the Social Policy of the General Assembly; Arkansas Interfaith Alliance; California Council of Churches; Catholic Health East, Pennsylvania; Detroit Interfaith Outreach Network; Faith Action Network of Washington; Holy Family Institute, Pennsylvania; Interfaith Health and Hope Coalition, Michigan; Ohio Council of Churches; Progressive Action for the Common Good, Iowa, Illinois; Michigan Unitarian Universalist Social Justice Network; Missouri Health Care for All; Missouri Interfaith IMPACT; North Carolina Council of Churches; Social Justice

moral imperatives that impel the faith communities to support the Medicaid expansions and improvements in the Affordable Care Act ("ACA"). The over 60 *amici* organizations noted in footnote two work together as coalition partners through Faithful Reform in Health Care and/or the Washington Interreligious Staff Community (WISC) Health Care Working Group.

Faithful Reform in Health Care, founded in 2007, is the largest interfaith coalition of national, state, and local organizations, congregations, and individuals working together around a shared moral vision for the kind of health system that would include everyone. Comprising Protestants, Catholics,

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Mission Area Team, Detroit Metropolitan Association, United Church of Christ; Texas Impact; Wisconsin Council of Churches; Benedictine Sisters, Boerne, Texas; Congregation of the Sisters of Charity of the Incarnate Word, Texas; Dominican Congregation of Our Lady of the Rosary, New York; Dominican Sisters of Hope; Justice and Peace Committee of the Sisters of St. Joseph of Springfield, Massachusetts; Marianist Province of the United States; Sisters of Charity of St. Elizabeth Leadership Team, New Jersey; Sisters of Charity of St. Vincent De Paul of New York; Sisters of the Holy Cross Congregation Justice Committee; Sisters of the Incarnate Word and Blessed Sacrament, Corpus Christi, Texas; Sisters of Mercy West Midwest Justice Team, Nebraska; Sisters of the Most Precious Blood, Missouri; Sisters of the Presentation of the Blessed Virgin Mary, New York; Sisters of St. Dominic Congregation of the Most Holy Name; Society of the Holy Child Jesus, American Province Leadership Team; Ursuline Sisters of Tildonk, US Province; JOLT, Catholic Coalition for Responsible Investing; Region VI Coalition for Responsible Investment, Ohio, Kentucky, Tennessee; School Sisters of Notre Dame Cooperative Investment Fund; Tri-State Coalition for Responsible Investment; Cote Brilliante Presbyterian Church, Missouri; Parkside Community Church, United Church of Christ, California; and United Methodist Women, Biltmore United Methodist Church.

Evangelical Christians, Jews, Muslims, Unitarians, Buddhists, and others, the coalition has focused on educating its members about the challenges in U.S. health care, as well as the needed changes in public policy that could lead to the creation of a health care system that better meets the needs of all. In addition to advocating system reform generally, when necessary, the coalition has engaged in educational and advocacy efforts specifically focused on protecting, strengthening, and expanding programs such as Medicaid, the Children's Health Insurance Program ("CHIP"), and Medicare. Supporting the Medicaid improvements and expansions in the ACA is consistent with the Coalition's history and mission.

The WISC Health Care Working Group provides a forum through which leaders in the Washington, D.C. offices of national faith groups connect to one another around numerous health care issues. The missional activities of the group include maintaining relationships with the legislative and executive branches of the federal government; communicating legislative activities to their constituencies; communicating moral priorities to the President and Congress; and engaging in education and advocacy around health care issues that are addressed by the social justice policies of the member organizations. This group has consistently served as the link between federal policy and outreach and the work of the Faithful Reform coalition, including efforts that focus on Medicaid, CHIP, and Medicare.

Amici believe that passage of the ACA, which included important Medicaid improvements and expansions, marked a significant step toward the faith community's long-held vision of a system of health care that includes, and works well for, all.

Amici celebrate the ACA as the first time our country successfully made a national legislative commitment to develop a health care system that will give almost everyone in the United States access to our nation's abundant health care resources.

For decades, faith communities have worked both individually and collectively to move our nation toward a more inclusive and just system of health care—with particular focus on the poor and vulnerable. Since 2008 *amici* have been guided in their work by "A Faith-Inspired Vision of Health Care," an interfaith statement of the shared value of health care for all. (*Available at* http://www.faithfulreform.org and printed for the Court's convenience in Appendix A). Hundreds of organizations and thousands of individuals representing every state signed on to this vision statement, and Faithful Reform in Health Care delivered it to President Obama and Members of Congress on several occasions to help identify the faith community's perspective on how a present day government might respond to the moral imperative of health care for all.

This vision states, "As people of faith, we envision a society where each person is afforded health, wholeness, and human dignity." That vision embraces a system of health care that is: inclusive, affirming that health care is a shared responsibility grounded in our common humanity; affordable, confirming that health care must contribute to the common good by being affordable for individuals, families and society as a whole; accessible, ensuring that all persons have the health services that provide necessary care and contribute to wellness; and accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community. Id.

Amici have been among those at the heart of support for meaningful health care reform in the United States. Grounded in values that inspire them to work on behalf of the common good, *amici* have promoted a moral vision for the nation's health care future and raised voices in support of affordable quality health care for all. Such commitment is a logical extension of *amici's* calling to bring comfort and healing to those who suffer, with particular concern for the poor and vulnerable who are served by Medicaid and for whom the ACA's Medicaid provisions are particularly significant.

SUMMARY OF ARGUMENT

Amici represent those faith communities that characterize our country's religious diversity. While these groups have different perspectives on many issues, they all agree that it is the calling of government to bring justice and protection to the poor and the sick, a goal that is consistent with the U.S. Constitution. For this reason, *amici* have long supported Medicaid, our nation's program for health care for the poor.

The Medicaid program was created as an amendment (Title XIX) to the Social Security Act ("SSA"). Congress passed the original SSA in the depths of the Great Depression because the states, which had traditionally provided for the welfare of the poor, were overwhelmed by the extent of the need. The SSA created the cooperative federal and state assistance programs upon which Medicaid was ultimately based. Although the original SSA did not include health insurance, the statute was amended in the 1950s and 1960s to provide the states with some health care funding. Later, the Medicaid program,

created by 1965 amendments to the SSA, firmly established a federal role in funding health care and provided a legal framework for state Medicaid programs.

State Medicaid programs vary considerably. To ensure a level of minimum coverage from state to state, however, the federal government requires that the states furnish certain levels of services and cover certain populations. Since 1965, Congress has regularly expanded that coverage under the Medicaid program. The ACA's Medicaid expansions are only the latest in this series and complete a long-term trend of expanding Medicaid to cover all poor Americans.

Congress expanded Medicaid through the ACA in response to another historical crisis—the needs of fifty million uninsured Americans, many of whom are too poor to afford health insurance. Although pre-ACA Medicaid expansions and the creation of CHIP decreased dramatically the percentage of uninsured American children, the number of uninsured American adults has continued to grow. The ACA's Medicaid expansions respond to this crisis, expanding health care coverage to all adults with incomes below 133 percent of the federal poverty level.

This expansion is morally proper and legally permissible. Neither the facts nor the case law support any conclusion that states are or will be improperly coerced into participating in Medicaid. Congress has never required the states to participate in Medicaid. Rather, the ACA offers the states generous support for Medicaid expansion, 100 percent of which will be paid for by the federal government in the near term. Because states can opt out of Medicaid, the only compulsion they face is the knowledge that the

Medicaid expansion is the right and moral thing to do. This Court, therefore, should reject the states' claim and affirm the constitutionality of the ACA's Medicaid expansions.

ARGUMENT

I. THE OBLIGATION TO CARE FOR THE HEALTH OF THE POOR, UNIVERSALLY RECOGNIZED BY RELIGIOUS ORGANIZATIONS, IS AMONG THIS COUNTRY'S FUNDAMENTAL VALUES AND IS FURTHERED BY THE ACA'S EXPANSION OF MEDICAID.

When the people of the United States established a Constitution for its government, they identified a significant purpose of government as promoting the general welfare. In so doing, they identified a moral imperative of government: to seek the common good of the American people. The faith community understands and endorses the government's legitimate and necessary role in promoting the common good.[3] The scriptures of the Abrahamic traditions of Christians, Jews, and Muslims, in addition to the sacred teachings of other faiths, understand that addressing the general welfare of the nation includes giving particular attention to the poor and the sick.

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[3] For instance, the Presbyterian Church (U.S.A.) summarized what many faith groups affirm – that ". . . civil government is ordained by God to order and serve the human community and therefore is to be held in high respect and honor . . . The civil state by its own definition and tradition is to serve the causes of justice, the common well being." Presbyterian Church (U.S.A.) 200th General Assembly Minutes, Part I (1988) p. 47.

In the most ancient of sacred teachings, this special concern was addressed to the orphan, the widow, and the alien, who at that time were among the poorest and most vulnerable. Some of these teachings enjoin the population from mistreating or oppressing the orphan, the widow or the alien (Exodus 22:21-24, Deuteronomy 24:17-21; Zechariah 7:8-10). Some teachings promote positive acts on behalf of poor and vulnerable people. Those with fields or grape arbors are commanded to leave a portion for the poor and vulnerable (Deuteronomy 14:28-29, 15:7-11, 26:12). Jesus equates faithfulness with feeding the hungry, giving drink to the thirsty, welcoming strangers, healing the sick, and visiting the imprisoned, when he says, "whatever you did for the least of these my brothers and sisters of mine, you did for me." (Matthew 25:37-40). Similarly, Muslims, as one of their five obligations, are to give alms for the poor, the needy, the workers who collect them, and those burdened by unexpected expenses. (The Holy Qur'an 9:60). Thus, acts on behalf of the needy and vulnerable, whether volunteered as individuals or commanded by society, formed the framework of the understanding of right and wrong in the history of Judaism, Christianity, and Islam.

These teachings regarding the moral imperative to provide assistance to the poor and the needy are addressed not only to individuals, but to societies and governments—requiring not only individual charity, but also social justice. These teachings extend not only to the food and property of the poor, but also their health care. Addressing the failure of Israel's government, the prophet Ezekiel (34:4) makes his accusation: "You have not strengthened the weak, you have not healed the sick, you have not bound up the injured." The prophet Jeremiah (8:22) echoes

that accusation with a question: "Why, then, has the health of my poor people not been restored?"

Out of such teachings, common to this country's faith traditions, diverse faith communities created in 2011 an "Interfaith Statement of Principles: Protecting Medicaid and Medicare," which they forwarded to President Obama and Members of Congress to affirm their commitment to Medicaid as a program that serves the poor and vulnerable. The principles affirmed that:

> all individuals, regardless of their age, income, gender, gender identity, sexual orientation, race or ethnicity, geography, employment status, or health status, deserve equal access to quality, affordable, inclusive and accountable health care. Reducing health care options for some based on any of these factors is profoundly unjust . . . concern for the most vulnerable in our community, particularly low-income women, men and children and people with disabilities, is at the heart of our sacred texts and an affirmation of our common humanity.[4]

Medicaid—and its expansion through the ACA—embraces these principles and applies them to a national program that incentivizes the cooperation of states. Because Medicaid is an act of social responsibility, it is important to contrast it with acts of individual kindness. Individual acts of kindness to persons suffering ill health are commendable, but they cannot replace a nation-wide safety-net program like Medicaid, which currently serves millions of this

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[4] The full text of this statement is reproduced for the Court's convenience in Appendix B, also *available at* http://faithfulreform.org/storage/frhc/letters/medicaid_medicare_principles.pdf.

country's poor and vulnerable. Imagining that the matter could be addressed voluntarily by faith communities or other non-governmental entities also poses equitable concerns because voluntary acts conform to different standards or no standards at all.

The ACA bolsters Medicaid with nation-wide standards of care and eligibility, available at last to all low-income Americans. Comparable to the lawful establishment and administration of our nation's interstate highways, power grid, water supply, and communications systems, the ACA's Medicaid improvements and expansions help strengthen federal and state partnerships to create a seamless health care safety net that goes beyond the vagaries of mercy to the reliability of justice and fairness.

II. FAITH TEACHINGS ESTABLISHING A MORAL BASIS FOR HEALTH CARE TO THE POOR LED TO THE PASSAGE OF THE SSA, MEDICAID, AND THE ACA.

A. The SSA of 1935, Founded in a Moral Concern for the Needy, Established the Foundation on Which Subsequent Programs Have Been Built.

The moral imperative to care for the needs of the sick and the poor, advanced by the moral philosophy of *amici*, is at the foundation of the United States', and its constituent states', commitment to the Medicaid program. While our nation chose in its Constitution to eschew an established religion (U.S. Const. amend. I), many of those persons who formed this nation, and many citizens today, are people of faith. Even Americans who do not subscribe to an organized religion have imbibed the values of the faith traditions represented by the *amici* through

their families, heritage, educational institutions, or simply from the ambient American culture.

These moral teachings were the values that, on June 8, 1934, President Roosevelt invoked for a nation in the depths of the greatest depression it had known. The nation faced a crisis of immense proportions, with 18 million Americans on emergency relief and 10 million out of work. In the face of this catastrophe, President Roosevelt addressed Congress, explaining that:

> Our task of reconstruction does not require the creation of new and strange values. It is rather the finding of the way once more to known, but to some degree forgotten, ideals and values. If the means and details are in some instances new the objectives are as permanent as human nature.

Available at http://www.ssa.gov/history/fdrstmts.html #message1.

President Roosevelt appointed the Committee on Economic Security ("CES" or "the Committee") to recommend a course of action to address this crisis. In its 1935 Report, the Committee described the "ravages of probably the worst depression of all time," but also observed that even in "'normal times' . . . a large part of our population had little security." Report of the Committee on Economic Security, 1935, *available at* http://www.ssa.gov/history/reports/ces/ ces5.html. In particular, the Committee recognized the financial burden that illness and accidents imposed upon lower-income Americans.

The Committee recommended a series of programs, which in turn laid the groundwork for the SSA of 1935. These programs, the Committee reported recalling Roosevelt's address, represented not:

> a change in values but rather a return to values lost in the course of our economic development and expansion. The road to these values is the way to progress. We will not rest content until we have done our utmost to move forward on that road.

Id. at 3 (quoting President Roosevelt's message to Congress of June 8, 1934).

The values that Roosevelt and the CES endorsed were grounded in moral principles advanced by the religions of *amici*. As historian Lew Daly explains:

> What distinguished Roosevelt was his "deep conviction," as he said during his fiery 1936 campaign, "that democracy cannot live without that true religion which gives a nation a sense of justice and of moral purpose." The major religious bodies stood behind him in this, despite his own rather indifferent religious life . . . No president who preceded him in the 20th century had so religious a following, or anything close to it. And none had so much support from religious leaders and particularly from Catholic thinkers.

Lew Daly, *In Search of the Common Good: The Catholic Roots of American Liberalism*, Boston Review, May/June 2007. *Available at* http://bostonreview.net/BR32.3/daly.php.

The SSA of 1935, Pub. L. No. 74-271, 49 Stat. 620 (codified at 42 U.S.C. § 301 *et seq.*), embodied these values. It also recognized, given the scale of the financial catastrophe the nation faced, that the states could do more for the poor with federal-state cooperation. Thus, Title II of the Act established the national social insurance program that we know today as Social Security, while Titles I, IV, and

X, created cooperative federal-state public welfare programs for the elderly, families with dependent children, and the blind, and Title IX created a federal-state compensation program for the unemployed. *See* Legislative History, 1935 Social Security Act, *available at* http://www.ssa.gov/history/35actinx. html.

The SSA's new cooperative federal-state programs offered states federal funding for state-administered programs to be operated under rules laid down in the SSA. The states quickly embraced the new federal-state cooperative approach to public assistance, accepting both federal money to carry out responsibilities they had previously tried to cover with state funds and the federal conditions that came with the money. By 1938 every state had established one or more of the cooperative public assistance programs. Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid*, 12 (rev. 2003). Notably, under the Act, provision of federal funding for the cash assistance programs was expressly conditioned on state compliance with the federal conditions, and funding could be withdrawn in the event of noncompliance. SSA, Pub. L. No. 74-271, §§ 4, 404, and 1004.

The SSA created a legal framework for cooperative federal-state programs that has since become the model for many American social welfare programs. Participation is voluntary, but states that wish to receive federal financial assistance to offset the costs the program must operate under a federally approved "state plan." Federal law sets minimum, mandatory requirements, but states retain great discretion to use federal matching funds to go beyond the minimum required by federal law. Many of these requirements continue to apply to the Medicaid pro-

gram today. Timothy S. Jost, *Disentitlement? The Threats Facing our Public Health-Care Programs and a Rights-Based Response*, 76 (2003).

B. The Medicaid Program Builds on the Moral and Legal Foundation of the SSA.

The CES specifically recognized the costs sickness imposed on the poor:

> Illness is one of the major causes of economic insecurity which threaten people of small means in good times as in bad. In normal times from one-third to one-half of all dependency can be traced to the economic effects of illness. . . . Families with small incomes are compelled to sacrifice other essentials of decent living when serious illness strikes some member, go without needed medical care, or depend upon the gratuitous or near gratuitous services of doctors and hospitals. CES Rep. at 38-39.

While the CES did not recommend the creation of a medical assistance program, and the SSA did not provide for payment for medical care, the SSA expressly included provisions for further expansion and amendment. Specifically, Section 1104 of the original Act, "reservation of power," stated: "The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress." 42 U.S.C. § 1304.[5]

Exercising its power to amend, Congress soon began making incremental provisions for medical

[5] This Court has repeatedly recognized Congress' authority to change the SSA at its discretion. *Bowen v. Public Agencies Opposed to Social Sec. Entrapment*, 477 U.S. 41 (1986); *Flemming v. Nestor,* 363 U.S. 603, 610-611 (1960).

assistance for defined categories of individuals. The SSA Amendments of 1950 added a new federal-state cooperative program offering "medical assistance" for public assistance recipients. SSA Amendments of 1950, Pub. L. No. 81-743, 64 Stat. 477, 555. Stevens & Stevens, *Welfare Medicine in America* at 21-24. Further amendments to the SSA in 1960 authorized the Kerr-Mills program, which expanded federal matching funds for elderly recipients of cash assistance and for the first time offered federal funding for state programs for the "medically needy," elderly persons who did not meet state cash assistance eligibility requirements but who were impoverished by high medical costs. SSA Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924, 987; Stevens & Stevens, *Welfare Medicine in America* at 26-31.

These steps all led to Congress' 1965 passage of the Medicaid program, another cooperative federal-state program for "medical assistance." SSA Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. The Medicaid program, unlike the earlier cooperative medical assistance programs, required states to provide medical assistance to all persons eligible under a SSA cash assistance program and to provide assistance of the same "amount, duration, and scope" to recipients under all programs. 79 Stat. at 344. States also were given the option to cover other aged, blind, disabled and dependent families who were not eligible for cash assistance but were "medically needy" because of high medical bills. *See* 79 Stat. at 351.

Medicaid was adopted to help those "persons who were most impoverished and who-because of their physical characteristics-were often least able to overcome the effects of poverty." *Schweiker v. Hogan*, 457

U.S. 569, 590 (1982). "Medicaid," in the words of former Senator William Roth (R-Del.), "when it serves the most vulnerable, particularly America's children, is moral. And these feelings are shared mutually by Republicans on the committee as well as Democrats." 143 Cong. Rec. S6058, S6067 (June 23, 1997). In short, Medicaid promotes the same values as the original SSA.

C. The ACA's Medicaid Expansions are Built on the Same Framework and Serve the Same Moral Purposes as the Original SSA.

As the National Health Law Program's brief documents, the Medicaid program has been expanded many times since 1965 to cover the disabled, the elderly, children, and pregnant women. Many of the eligibility expansions were optional for the states, but significant expansions were mandatory. Whenever Congress added new mandatory categories, it conditioned federal funding on covering the new category. *See Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004) ("State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements."). This has been true of all federal-state Public Assistance Programs since the initial SSA of 1935 and of Medicaid since 1965, and it continues to be true today. *See, e.g.,* Resp't Br. at pp. 5-7.

As the Medicaid program has expanded, it has also evolved. The original Medicaid program was coupled mostly with cash assistance programs, with the mandatory and optional categories of eligibility tied to cash assistance eligibility categories—the aged, blind, and disabled and families with dependent children. Eligibility levels were set by the states.

Over time, however, Medicaid has been increasingly uncoupled from cash assistance. Indeed, with the end of the Aid to Families with Dependent Children program in 1997, Medicaid became a largely free-standing program, entirely separate from state cash assistance. By the 1980s, and continuing today, most recipients' eligibility is determined by criteria set by the federal government. *See* Kaiser Commission on Medicaid and the Uninsured, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services* (2005), *available at* http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf.

The ACA's Medicaid expansions to which the states object here are only the latest in this series of mandatory expansions to the Medicaid program. They continue the trend of prior federal expansions, extending Medicaid to a new category of recipients whose eligibility is defined by household income rather than by cash assistance eligibility. These expansions are the most recent chapter in our nation's attempt to achieve the, "security of the men women and children of the Nation . . . against misfortunes which cannot be wholly eliminated in this man-made world of ours," that President Roosevelt demanded in 1934. CES Report at 1. As Congressman Tim Ryan (D-Ohio) observed on the floor of the House, urging the passage of the ACA days before its adoption:

> We can't keep telling citizens in the wealthiest country that this globe has ever seen that we have the ability to care for you, but we can't afford it. It's time to pass this bill. We're going to do it this weekend. And we're going to look back, just like on Medicaid, Medicare, Social

> Security, and civil rights. We did the right thing, the moral thing.

156 Cong. Rec. H1691, H1695 (March 19, 2010).

III. THERE IS NO LEGAL COMPULSION FOR STATES TO PARTICIPATE IN MEDICAID AS EXPANDED BY THE ACA, ONLY A MORAL IMPERATIVE.

A. The States are Subject to the Same Moral Imperative as the Federal Government.

The values that drove the adoption of the SSA also impelled the states to cooperate with the federal government in participating in the SSA's assistance programs. The moral imperative to care for the poor and the sick speaks not only to the federal government, but also to the states—and both have responded.

There is a long tradition in the United States of state and local programs to care for the poor and needy antedating the SSA. Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* 133, 215-16 (10th ed. 1996). At first this took the form of almshouses and charity hospitals. By the time of the Roosevelt administration, however, many state and local governments had established more formal programs to provide cash assistance and emergency relief, as well as dispensaries to address the medical needs of the poor. In fact, by the time the SSA was adopted, 33 states had old age assistance programs, 45 states had mothers' pension statutes, and 24 states had pension programs for the blind. S. Rep. No. 74-628, at 4, 17, 22 (1935).

States also had medical assistance programs before the federal government, with the SSA Amendments of 1950, began helping to fund these programs. Although not all of the states participated in programs created by the 1950 Amendments or in the later Kerr-Mills program, general participation in the Medicaid program was almost immediate. By 1968, 37 states participated in the program, and most of the rest implemented programs soon thereafter. Stevens and Stevens, *Welfare Medicine in America*, at 156. Indeed, Congress had to revise the Medicaid program in 1967 to limit federal contributions for state programs because some states had raised eligibility levels so high.

Nevertheless, the states have never been required to participate in the Medicaid program. Although most states quickly joined the program once it became available, not all of them did. Arizona, for example, did not participate until 1982. Why, one might ask, did the states participate? The simple answer is that states are compelled by the same inescapable moral imperative as the federal government, and Medicaid has enabled them to meet this imperative with federal assistance.

B. Congress Has Not Improperly Coerced the States to Participate in Medicaid.

1. The Constitutionality of SSA Federal-State Programs is Well Established.

This is not the first challenge to Congress' authority to impose requirements through SSA Spending Clause programs. The SSA faced challenges immediately after its adoption. A trio of cases decided on May 24, 1937—*Helvering v. Davis*, 301 U.S. 619

(1937); *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937); and *Carmichael v. Southern Coal & Coke Co.*, 301 U.S. 495 (1937)—upheld the constitutionality of the federal Social Security program and the new federal-state cooperative unemployment program.

In *Helvering*, this Court held that Title II, the social insurance program for the elderly, neither exceeded Congress' powers under the Spending Clause nor violated the Tenth Amendment. In so holding, the Court recognized:

> The problem [of poverty among the elderly] is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. . . . States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged. . . . Apart from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors. . . . . Only a power that is national can serve the interests of all.

301 U.S. at 644.

The Court in *Steward Machine* reached the same result. The states here cite *Steward Machine* repeatedly because it is the origin of the coercion theory that they urge on this Court, even though the Court expressly found no coercion there. The Petitioner employer in *Steward Machine* challenged Title IX of the SSA. Under Title IX, the federal government taxed employers to fund a federal

unemployment compensation program, but employers could obtain a credit of up to 90 percent against the federal tax if they paid taxes into a state unemployment compensation program that met federal requirements, including a requirement that state program reserves be invested in a federal unemployment trust fund.

The Petitioner claimed that the SSA's 90 percent credit to employers on their federal unemployment tax for unemployment taxes paid to the states "coerced" the states into adopting unemployment compensation programs that complied with all of the federal requirements. Petitioner argued that employers in states that operated an independent unemployment compensation program that did not comply with federal conditions would purportedly face double taxation, paying taxes both to the federal government and to the state government to finance unemployment compensation programs. That argument is the same as the states present in this case: that their residents would face double taxation if the states opt out of Medicaid and finance their own program to fund health care for the poor.

The Court in *Steward Machine* began its analysis by considering the moral purpose served by the SSA. 301 U.S. at 586-89. Again, the Court recognized that the nation faced a national crisis that could not be solved by the states acting alone, not only because of the scope of the resources needed, but also because any state that imposed taxes to fund the program would lose employers to states that failed to do so. 301 U.S. at 588. The federal law essentially solved this dilemma.

Turning its attention to the coercion issue, the Court observed:

> The difficulty with the petitioner's contention is that it confuses motive with coercion. . . . *[T]o hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties*. . . . Till now the law has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems. Nothing in the case suggests the exertion of a power akin to undue influence, *if we assume that such a concept can ever be applied with fitness to the relations between state and nation*. Even on that assumption the 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. (emphasis added).

301 U.S. at 589-90.

In the third 1937 case, *Southern Coal & Coke* challenged Alabama's unemployment compensation law enacted pursuant to the SSA, and thus indirectly challenged the SSA itself. The Petitioner again claimed the SSA was coercive, and this Court again rejected the claim, citing *Steward Machine's* conclusion that:

> . . . the Social Security Act has no such coercive effect. . . . The United States and the State of Alabama are not alien governments. They coexist within the same territory. Unemployment within it is their common concern. Together the two statutes now before us embody a cooperative legislative effort by state and national governments for carrying out a public

> purpose common to both, which neither could fully achieve without the cooperation of the other. The Constitution does not prohibit such cooperation.

301 U.S. at 526. The Court further observed that the state legislature was free to repeal the state statute and to withdraw from the federal program at any time. *Id.*

This Court recognized in all three cases that the SSA's federal-state programs were cooperative programs, established as our nation's response to the "call of the distressed" prompted by the "disaster" of unemployment to breadwinners and their dependents, and grounded in "social and moral" as well as "fiscal and economic" foundations. *Steward Machine*, 301 U.S. at 587. The federal and state governments engaged in the programs as free actors, acting only under moral, not legal, compulsion. The states had addressed the problem of poverty on their own before the SSA, and were free to do so again, but the SSA allowed them to fulfill the moral imperative with assistance from the federal government.

2. Petitioners' Coercion Arguments Fail.

(a) The Minimum Coverage Requirement Does Not Support Petitioners' Coercion Argument.

The Medicaid program, as the states note, has grown to be one of the federal and state governments' largest programs. Expansions in the Medicaid program have often been welcomed and supported by the states. Colleen M. Grogan and Vernon K. Smith, *From Charity Care to Medicaid: Governors, States, and the Transformation of American Health Care*, in

A Legacy of Innovation, Governors and Public Policy, 204, 216-18 (Ethan G. Sribnick, ed. 2008). Nevertheless, states have brought a number of legal challenges to the program, claiming, as the states do here, that the importance of the Medicaid program coerces their participation. The appellate courts have repeatedly rejected these claims, noting that states may choose whether or not to participate in Medicaid. *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-414 (D.C. Cir. 1981); *Padavan v. United States,* 82 F.3d 23, 28-29 (2d Cir. 1996), *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 294-95 (4th Cir. 2002). States are required to comply with the conditions imposed by the Medicaid program, including the adult program expansion requirement, only if they choose to participate in Medicaid. States retain, as *Steward Machine* observed, the free will not to participate. The only compulsion they face to participate is moral.

The states nevertheless contend that the ACA extensions are different from earlier coverage extensions. First, the states claim that the minimum coverage requirement (I.R.C. § 5000A) "requires Medicaid-eligible individuals to obtain and maintain insurance." Pet'rs' Br. at 11. Through this requirement, the states claim, the federal government forces states to cover the Medicaid expansions to permit their low-income residents to comply with the minimum requirement. But Petitioners' effort to distinguish the ACA from earlier amendments is greatly overstated, if not erroneous. In fact, the penalty provisions that enforce the minimum coverage requirement exempt virtually all persons eligible for Medicaid who cannot obtain health insurance

through their employment from any sanctions for failing to be insured.[6]

Second, the states claim that the ACA makes no alternative provision for financing health care for persons with household incomes below 100 percent of poverty, and thus forces states to expand Medicaid. But the ACA does not force states to provide health care for this population. Federal law has never required the states to provide health care for the poor. It has simply said, since 1950, that if states wish to provide health care for the poor through a

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[6] IRC § 5000A(e)(2) exempts from the penalty all persons with incomes below the income tax filing limit (currently $9,350 per individual and $18,700 per couple). IRC § 5000A(e)(1) further exempts every household that cannot purchase a "bronze" health insurance policy (basically a very high cost sharing policy) for less than eight percent of modified adjusted gross income. The Congressional Budget Office estimates that in 2016, a bronze level policy will cost about $4,500 to $5,000 per individual and $12,000 to $12,500 per family. Letter from Douglas W. Elmendorf, Director, CBO, to Sen. Olympia Snowe, (Jan. 11, 2010) *available at* http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf. An individual purchasing non-group coverage would have to earn at least $62,500 and a family $156,250—far more than the eligibility levels of the Medicaid expansions—before becoming subject to the penalty. IRC § 5000A(e)(1) does impose penalties on individuals who can secure health insurance through their employer if the employee's share of the premium costs 8 percent or less of modified adjusted household income. This would no doubt include some persons who would be eligible for Medicaid with income under 133 percent of the federal poverty level ($14,856 for an individual and $30,657 for a family of four in 2012). *See* Families USA, 2012 Annual Federal Poverty Guidelines, *available at* http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html. Most Medicaid-eligible persons, however, would not be subject to the penalty.

federally defined program, the federal government will help. It is, again, the moral law that compels the states to provide for the poor, not the federal law.

(b) The ACA's Generous Funding, Even With Conditions And No Tax Credits for States that Opt Out, Does Not Amount To Coercion.

Of course, Congress makes a generous offer to states that choose to expand Medicaid coverage. The ACA offers to cover 100 percent of the costs of the expansion coverage for the first three years, phasing down its share of the cost of coverage thereafter to 90 percent by 2020. This is far more than the matching rate customarily granted for Medicaid. Given the fact that states already cover some of the medical costs of the expansion population, many states are likely to save money rather than incur additional costs, even when the coverage expansions are fully implemented. January Angeles, Center on Budget & Policy Priorities, *Health Reform is a Good Deal for the States* (Jun. 18, 2010), *available at* http://www.cbpp.org/files/4-26-10health.pdf. The fact that Congress makes a generous offer, however, does not mean that the states must accept it. Again, the only compulsion they face is the "cry of the distressed," not the force of federal law.[7]

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[7] Furthermore, as the Eleventh Circuit noted below (*see Florida v. United States Dept. of Health and Human Servs.*, 648 F.3d 1235, 1268 (2011)), the statute contradicts the states' claim that they face mandatory loss of all funds if they fail to comply. 42 U.S.C. § 1396c provides ample agency discretion both in whether, and how much, a reduction in federal benefits may result. Thus, the states' allegation of legal compulsion is illusory for this reason alone.

Petitioners appear to recognize that they have a need to provide health care to their citizens and argue that federal funding is important, if not essential, to their fulfilling this need. As discussed below, their argument that the amount of federal funding at stake is so substantial that a choice to give up that funding without a commensurate tax credit leaves them no choice at all misses the mark. Moreover, the assumption that states will be unable to meet these needs without federal assistance is questionable.

The states have no automatic right to the federal funds; the federal government could terminate the Medicaid program today and, subject to resolving outstanding claims, would owe no tax dollars, as funding or credits, to the Petitioner states. It is axiomatic that the federal government would have an absolute right to maintain federal taxes (albeit relabeled) at existing levels and use revenue previously directed to health programs for the poor for other purposes. U.S. Const. art. I, § 8, cl. 1. The Petitioners would have no claim against the federal government in that event.

Along a similar vein, this Court had occasion to hold that tax credits, let alone federal funding, is not due and owing to a state when the state-level choices (which in this case would involve opting not to fulfill the conditions of Medicaid) cause a differential or adverse impact on an individual state. *See State of Florida v. Mellon*, 273 U.S. 12, 17 (1927) (noting "Congress cannot accommodate its legislation to the conflicting or dissimilar laws of the several states, nor control the diverse conditions to be found in the various states, which necessarily work unlike results from the enforcement of the same tax."). It does not follow, therefore, that the Petitioners can legitimately

claim legal coercion here where what they are really claiming is nothing more than a right to existing Medicaid funding levels for partial participation in the program or a right to a tax credit for opting out of the program. In the absence of this right, a coercion theory is wholly inapplicable and the Court need not evaluate the difficulty of the choice states must make under the ACA with respect to Medicaid.

Even so, it should not be presumed that states are incapable of providing for their residents with medical need without federal assistance. States vary widely on what they spend currently per resident on Medicaid. In 2008, for example, New York spent $9,056 per resident on Medicaid; Florida spent slightly more than half as much, $4,573. Kaiser Family Foundation, *Medicaid Payments per Enrollee*, FY 2008, *available at* http://www.statehealthfacts.org/comparemaptable.jsp?typ=4&ind=183&cat=4&sub=47&sortc=6&o=a. This was true even though New York covered 50 percent of its Medicaid costs from state funds while Florida covered only 43 percent of its costs. Kaiser Family Foundation, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, *available at* http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4. Many states currently provide health care for their lower-income uninsured residents who do not qualify for Medicaid through safety net programs and medical assistance programs, and they could continue to do so if they chose to opt out of Medicaid.

The Petitioner states, of course, are not asking to opt-out of the Medicaid program. They simply want the program to offer them a menu of optional benefits with no strings attached. Petitioners assert that their participation in Medicaid is, for purposes of a

Spending Clause analysis, subject to contract principles. Pet'rs' Br. at 26-27.[8] Although the states argue that the ACA's Medicaid expansion is unique in some way, it is, as noted above, no different from earlier Medicaid expansions, with which states must also comply as a condition of receiving any Medicaid funding.

Indeed, if this Court strikes down the requirement that states cover adults with incomes below 133 percent of the federal poverty level, it could also strike down requirements that states cover pregnant women and children up to age 5 with incomes below 133 percent of poverty, 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(2)(A)(ii); children age 5–18 with incomes up to 100 percent of poverty, 1396a(a)(10)(A)(i)(VII), 1396a(l)(2)(C); or Medicare cost-sharing for beneficiaries with incomes below 120 percent of poverty. 42 U.S.C. §1396a(a)(10)(E)(iv). Medicaid would simply become an assortment of optional programs. As noted in other *amicus* briefs in opposition to the states' claim, many other conditional federal programs would become subject to challenge as well, including many poverty, community development, education, and civil rights programs that are very important to our communities. Under such a decision, the relationship between the federal and state governments, recognized at least since May 24, 1937, would be at an end, and serious doubts would be raised about the federal

[8] Petitioners then ignore inconvenient contract principles that require them to abide by the bargain they struck when the states voluntarily agreed to participate in Medicaid, thereby receiving for decades generous funding from the federal government, subject to Congress' ongoing ability to amend Medicaid unilaterally.

government's authority to allocate taxpayer funds as it sees fit.

CONCLUSION

In the 1930s this country faced an unprecedented crisis of poverty and unemployment. Congress and the states rose to the occasion, adopting the SSA and implementing public welfare programs for the aged, blind, and dependent children across the nation. Today the nation faces another great challenge—providing basic health care for almost one sixth of the nation's uninsured population. The ACA rises to this challenge.

Nothing in the ACA requires states to participate in this expansion. The states resist simply withdrawing from Medicaid, however, because state legislators understand that they are subject to a greater law than the ACA—a moral imperative to care for the poor and the sick. The ACA broadens our nation's understanding of the moral imperative that has long grounded SSA programs. It brings us closer to the moral vision of our faith communities—a vision that recognizes the needs of all of those who cannot afford health care, not just those who fit into particular categorical pigeon holes. It does so within the limits of, and as an expression of, the United States Constitution's declaration that promotion of the general welfare is an essential purpose of legislation. The moral vision of American faith communities has been a proper and necessary consideration in legislative approaches to promoting the general welfare from the nation's inception. *Amici* urge this Court not to reject Congress' most recent response to the "call of the distressed." Like the district court and the court of appeals, this Court should uphold

the constitutionality of the Affordable Care Act's Medicaid expansion.

Respectfully submitted,

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APPENDIX

APPENDIX A

A FAITH-INSPIRED VISION OF HEALTH CARE

As people of faith, we envision a society where each person is afforded health, wholeness, and human dignity. That vision embraces a system of health care that is inclusive . . . accessible . . . affordable . . . and accountable.

Vision ~ Inclusive: Health care is a shared responsibility that is grounded in our common humanity. In the bonds of our human family, we are created to be equal. We are guided by a divine will to treat each person with dignity and to live together as an inclusive community. Affirming our commitment to the common good, we acknowledge our enduring responsibility to care for one another. As we recognize that society is whole only when we care for the most vulnerable among us, we are led to discern the human right to health care and wholeness. Therefore, we are called to act with compassion by sharing our abundant health care resources with everyone.

Vision ~ Affordable: Health care must contribute to the common good by being affordable for individuals, families and society as a whole. We believe that in the sacred act of creation we are endowed with the talents, wisdom and abundant resources necessary to meet the needs of one another, including the health care needs of all. Therefore, in our calling to be faithful stewards, we understand our responsibility to use our health care resources effectively, to administer them efficiently, and to distribute them with equity.

Vision ~ Accessible: All persons should have access to health services that provide necessary care and contribute to wellness. We believe humanity is sacred and that all persons should benefit from those actions which contribute to our health and wholeness. Therefore, we are called to act with justice and love, to ensure that all of us have access to the health care we need in order to live out the fullness of our potential both as individuals and as contributing members of our society. We must work together to identify and overcome all barriers to and disparities in such care.

Vision ~ Accountable: Our health care system must be accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community. We believe that as spiritual and sacred vessels, we are responsible for the care of our bodies to the best of our ability and for the care of one another regardless of individual circumstances. Therefore, individuals, families, governments, businesses, and the faith community are called to work in partnership for a system that ensures fully-informed, timely, quality and safe care that treats body, mind and spirit.

Developed by Faithful Reform in Health Care, signed by nearly 200 national, state, regional, and local faith organizations, and thousands of individuals. Delivered to the President and Members of Congress at numerous times by organizations and individuals 2009-2011.

APPENDIX B

Interfaith Statement of Principles: Protecting Medicaid and Medicare

Our organizations, as well as people of faith throughout our society, strongly support Medicaid and Medicare. In the faith community, we are often the first to witness need and distress from all causes. As providers of services and care, both physical and spiritual, our members, congregations and institutions, including religiously affiliated health care providers, are very familiar with the importance of Medicaid and Medicare.

We fully recognize that:

- Medicaid is the only program that provides comprehensive health coverage to low-income women, men, and children, the elderly, and people with disabilities. Medicaid's reach into every aspect of health care at every stage of life is remarkable, from the program's role in paying for nearly 40% of all live births to its role in funding the long-term care of seven out of 10 nursing home residents.
- Medicare is the primary source of health insurance for our nation's seniors. Coupled with Medicaid for seniors with low incomes, Medicare ensures that our seniors receive the health care they need.

In deliberations about how we address the competing priorities and needs of all those who live in the United States, we call upon our elected leaders to consider the following shared interfaith principles which inform our support for Medicaid and Medicare:

- As people of faith, we envision a society where each person is afforded health, wholeness and human dignity.
- All individuals, regardless of their age, income, gender, gender identity, sexual orientation, race or ethnicity, geography, employment status, or health status, deserve equal access to quality, affordable, inclusive and accountable health care. Reducing health care options for some based on any of these factors is profoundly unjust.
- The social safety net and its key components, including health care, must be maintained to reflect our shared commitment to protecting vulnerable populations.
- Concern for the most vulnerable in our community, particularly low-income women, men and children and people with disabilities, is at the heart of our sacred texts and an affirmation of our common humanity.
- Caring for our elders and treating them with dignity demonstrates the value we place on our enduring responsibility to enable all persons to live out the fullness of their days.

Together, Medicaid and Medicare address these principles and help fulfill our moral obligation to meet the needs of the most vulnerable members of our society. Inasmuch as the above principles guide our organizations and the millions of people of faith we represent in our support for Medicaid and Medicare, we urge our elected leaders to consider these principles in their discussions about the future of these life-saving programs.

Developed by the Washington Interreligious Staff Community Health Care Working Group and Faithful Reform in Health Care, signed by 60+ national, state, and regional faith organizations and delivered to the President and Members of Congress in 2011.