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Florida v. HHS - States Memorandum in Response to U.S. Motion for Summary Judgment

State of Florida

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

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

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

MARY BROWN, an individual; and

KAJ AHLBURG, an individual;

Plaintiffs,

v.

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

Defendants.

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PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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Plaintiffs hereby submit this memorandum in opposition to Defendants' Motion for Summary Judgment. As shown below – and as supported by Plaintiffs' Response to Defendants' Statement of Material Facts ("PRSOMF") and Supplemental Appendix ("Pl.Supp.App."), as well as the materials previously submitted in support of Plaintiffs' Motion for Summary Judgment – Defendants are not entitled to judgment in their favor on any claims in the Amended Complaint. Accordingly, their motion must be denied.

Introduction

As Plaintiffs have shown in their Motion for Summary Judgment [Doc. 80-1], the Patient Protection and Affordable Care Act[1] ("ACA" or "the Act") exceeds Congress's powers under Article I and violates the Ninth and Tenth Amendments. To sustain the Act, Defendants ask the Court to rewrite the Constitution and fundamentally alter the relationships between the federal government and the States and between the federal government and the American people. The Court should refuse this invitation.

A. The Individual Mandate Exceeds the Commerce Power

The Individual Mandate is unprecedented. It compels citizens to engage in commerce even though they have not themselves chosen to enter the marketplace. Never before has Congress purported to use its power over interstate commerce to *compel* activity, rather than to regulate *existing* economic activity. Nor has Congress ever suggested that such compulsion was "necessary" or "proper" for the regulation of interstate commerce. Moreover, prior to the ACA's enactment, no federal court ever had

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

endorsed the expansive view of the Commerce Clause and Necessary and Proper Clause on which Defendants' efforts to justify the mandate depend. Mem. Op. [Doc. 79] at 61.

Limiting the commerce power to the regulation of existing commercial activity, whether the activity is directly in or has a substantial effect on interstate commerce, provides a necessary and judicially manageable restraint on congressional authority – a restraint grounded in the text and history of the Constitution, as well as binding precedent. Although Defendants demand that the Court abandon this time-tested limitation on Congress's authority to regulate "Commerce ... among the several States," they can offer no substitute limiting principle that would prevent the Commerce and Necessary and Proper Clauses from becoming the very sort of general police power the Framers specifically denied to the federal government.

Moreover, such a ruling impermissibly would render numerous other powers of Congress redundant and limitations on Congress unavailing. This Court should not endorse a boundless expansion of federal power so at odds with the basic language and premises of the Constitution, its historical protection of the rights of the States and the People *vis-à-vis* the federal government, and the axiomatic rules of constitutional construction dating back to *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

B. The ACA's Medicaid Regime Impermissibly Coerces and Commandeers the States

The ACA further violates the Constitution by coercing the States' participation in its new Medicaid regime and by commandeering their resources to achieve the federal government's ends. The federal-State Medicaid partnership does not confer plenary power on the federal government to make *any* Medicaid revisions that it wishes,

irrespective of coercion or harm to the States. Where Medicaid was created as a federal-State partnership to provide funding to reimburse the healthcare costs of the poor and needy, the ACA scuttles that partnership and imposes a vastly transformed Medicaid on the States. Now, Medicaid funding is to be made available to everyone with an income up to 38 percent *above* the federal poverty level; the States (but *not* the federal government) are to assume responsibility for the *provision* of healthcare services (rather than merely reimbursing the costs of those services); and the States' flexibility to alter eligibility criteria and to control costs through the withdrawal of optional benefits – comprising more than 60 percent of Medicaid spending – has been removed. The ACA's Medicaid changes are forecast – by federal agencies tasked with scoring the ACA's projected impact, by States, and by another respected healthcare organization – to cost the States *at least* $20 billion by 2019, and more likely *double* that figure, not counting their added administrative overhead or the cost to them from becoming responsible for providing healthcare services. PRSOMF ¶¶ 40, 47. Indeed, the latter cost alone could bankrupt States, which probably explains why Congress refused to share that new burden. These greatly increased costs are imposed at a time when, by the federal government's own reckoning, the States must *decrease* their Medicaid outlays to avoid insolvency.

Congress's top-down transformation of Medicaid was done to advance the ACA's overarching goal of achieving near-universal healthcare insurance coverage. The Individual Mandate requires that virtually every American must obtain qualified coverage, and the Act provides four primary "doors" through which a person may pass to get that coverage: Medicaid, Medicare, statewide insurance exchanges, and employer

plans. Congress's overhaul of Medicaid widens that "door" considerably, in order to accommodate about 18 million (30 percent) more enrollees. PRSOMF ¶ 43.

Defendants ask the Court to believe that Medicaid remains purely voluntary, and that any State may simply withdraw to avoid the new costs and burdens. However, there is no mechanism under law for such a withdrawal – much less for an orderly transition that would not jeopardize the health and lives of the millions of poor and needy who depend on the States' Medicaid programs. Defendants' contention is especially disingenuous, because Congress very well knew in passing the ACA that withdrawal would not be a viable alternative for the States. The ACA's architecture inherently depends on the States remaining in Medicaid. A withdrawal would tear a gaping hole in the ACA's scheme, locking shut the "door" by which the Act provides for 70-80 million lower-income Americans to comply with the Individual Mandate; no federal provision is made to fund their healthcare needs *except through Medicaid*. States' withdrawal not only would frustrate the ACA's universal coverage objective, but would end up leaving the poorest and neediest out in the cold even while federal subsidies would be lavished on millions of other persons at far higher income levels.

Defendants' remaining contentions are specious. First, they note that the federal government will be spending more under the new Medicaid regime than will the States. But the level of the federal government's contribution fails to address the substantial new costs and burdens placed on the States. Moreover, likening federal and State fiscs is akin to comparing apples and oranges, because the States – unlike the federal government –

cannot tax at rates equal to the federal government, cannot print money to cover their debts, and cannot pile up deficits the size of the federal government's.

Second, Defendants offer the preposterous claim that the States will achieve net *savings* under the transformed Medicaid program. As a threshold matter, this claim is legally irrelevant to the coercion analysis. Defendants do not dispute the costs and burdens forced onto the States, but merely point to the *potential* for States to receive collateral benefits. In fact, Defendants have no credible support for their claim of offsetting savings. They place primary reliance on a report by the President's own Council of Economic Advisors ("CEA"), made months before the ACA's passage. But the CEA report is rife with error and mostly identifies potential "savings" that would not accrue to the States' fiscs at all; rather, the identified beneficiaries are *local* governments – and any savings to *them* are questionable and, if realized, might actually *increase* States' costs. PRSOMF ¶¶ 48-57. Hence, it is no wonder that the federal agencies and outside organizations that assessed likely projected costs of the ACA *did not even cite the CEA report*. Instead, they project significant net costs to the States, as do the sworn declarations from representatives of Plaintiff States' Medicaid agencies.

There is no room for reasonable disagreement: the transformed Medicaid regime far surpasses the point at which persuasion becomes coercion, in violation of the Constitution. In addition, it violates every restriction on Congress's spending power.

Finally, neither the ACA's Medicaid changes nor the Individual Mandate is severable from the other provisions of the ACA. The unconstitutionality of either requires that the Act be struck down in its entirety.

Argument

I. THE INDIVIDUAL MANDATE IS UNCONSTITUTIONAL

A. The Commerce Power Has Limits That Congress Must Respect

Congress's power under the Commerce Clause, even as augmented by the Necessary and Proper Clause, is not unlimited. It is firmly established that the Constitution created a federal government of limited, "'enumerated powers' ... which means that '[e]very law enacted by Congress must be based on one or more of' those powers." *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (citations omitted). As a result, however broad Congress's enumerated powers may be, they cannot be interpreted in a manner that would encompass a general police power. *Id.* at 1964 (confirming that its decision does not "confer[] on Congress a general 'police power, which the Founders denied the National Government and reposed in the States.'") (quoting *United States v. Morrison*, 529 U.S. 598, 618 (2000)).

Several equally fundamental rules derive from that most basic premise. First, the Commerce Clause itself grants a limited power constrained by the very language of that provision. *United States v. Lopez*, 514 U.S. 549, 552–553 (1995) ("[t]he Constitution creates a Federal Government of enumerated powers," and there are limits that "are inherent in the very language of the Commerce Clause."); *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 194-95 (1824) (the very existence of an "enumeration presupposes something not enumerated") (quoted in *Lopez,* 514 U.S. at 551).

Second, the Necessary and Proper Clause, providing adjunct or incidental authority required for "carrying into Execution" Congress's regulation of interstate

commerce, likewise must be limited so that it does not vitiate the intrinsic limits on the underlying power.

Third, "[t]he commerce power – that is the combination of the Commerce Clause per se and the Necessary and Proper Clause," *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1249 (11th Cir. 2008), cannot be interpreted in a manner that renders meaningless either the Constitution's grant of other limited powers to Congress or the affirmative restrictions it imposes on those powers in general. "It cannot be presumed that any clause in the constitution is intended to be without effect; and therefore such a construction is inadmissible, unless the words require it." *Marbury*, 5 U.S. at 174.

In light of these fundamental principles, Defendants' attempts to justify the Individual Mandate all fail.

B. The Commerce Power Does Not Support the Individual Mandate

Defendants argue that the Individual Mandate falls within the commerce power because all individuals eventually will consume healthcare and some will be unable to pay for that care, effectively "shifting" these costs to third parties. Congress, Defendants claim, may preemptively require insurance to avoid such "cost-shifting." DMSJ [Doc. 82-1] at 25-27. However, this convoluted reasoning conflates actual commerce with potential future commerce, and with failures or refusals to engage in present commerce, ultimately collapsing into the proposition that the absence of engagement in one type of commerce (purchasing healthcare insurance) can be regulated by Congress because it may affect another type of commerce (the consumption of healthcare services) and the economy in general. Defendants' position is profoundly flawed.

1. The Individual Mandate Does Not Regulate the Healthcare Services Market

First, the Individual Mandate does not regulate the only actual commerce identified in Defendants' daisy-chain. The purchase of healthcare services is, of course, a commercial transaction, though it is typically a local and intrastate transaction rather than an interstate one.[2] But the mandate does not regulate the purchase or consumption of healthcare services. It does not constrain the type of care consumed or *require* consumers to pay for such care in any particular manner. Healthcare services still may be purchased on a pay-as-you-go basis, and often will be so purchased, particularly where any desired care exceeds the coverage of ACA-approved insurance policies. Thus, requiring individuals to purchase healthcare *insurance* does not regulate the consumption of healthcare *services*.[3]

2. The Commerce Power Only Reaches Activity

Second, the Individual Mandate does not regulate any "activities" that constitute interstate commerce or that "substantially affect interstate commerce." *Gonzales v. Raich*, 545 U.S. 1, 16–17 (2005). Compelling individuals to engage in a particular type of commerce, in order to create economic activity, is not the *regulation* of interstate

[2] Any regulation of such intrastate transactions thus already is one step removed from the regulation of interstate commerce and could be justified only because it might have an effect on interstate commerce and be necessary and proper to carry into execution the regulation of such interstate commerce.

[3] In this connection, Defendants also incorrectly assert that the Individual Mandate may constitutionally be applied to those who *now* have healthcare insurance – presumably on the assumption that having entered the market for such insurance they may never leave it. There is no authority for such a proposition.

commerce. That power presupposes the existence of the commerce being regulated.[4] Here, Congress seeks to regulate inactivity, or the *absence* of interstate commerce, by forcing commercial transactions on those who elect not to purchase insurance and thus *not* to engage in current interstate commerce. Notwithstanding Defendants' verbal gymnastics, inactivity or the absence of commerce cannot be conflated with activity and commerce without rendering the word "commerce" itself meaningless.

Moreover, as the very enumeration of a power to regulate interstate commerce "presupposes something not enumerated," *Lopez,* 514 U.S. at 551 (quoting *Gibbons v. Ogden*, 22 U.S. at 194-195), there must be a category of "*non*-interstate commerce" – *i.e.*, economic activity which truly is local and beyond Congress's reach. *Id.* at 557 (citing *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937)). One obvious and historically grounded aspect of the category of human existence not subject to the commerce power is simple passivity, or the failure to engage in commercial transactions.

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[4] This is a limit inherent in the text and structure of the Constitution itself. To the Framing generation, "commerce" was essentially "trade." Samuel Johnson, *A Dictionary of the English Language* (J.F. Rivington, et al., eds., 6th ed. 1785) ("Intercourse; exchange of one thing for another; interchange of any thing; trade; traffick."). *Accord* Noah Webster, *An American Dictionary of the English Language* (1828) ("an interchange or mutual change of goods, wares, productions, or property of any kind, between nations or individuals, either by barter, or by purchase and sale; trade; traffick."). Evidence from the drafting of the Constitution, the Federalist Papers, ratification debates and conventions, and early judicial interpretations confirms this understanding. *See* Randy E. Barnett, *The Original Meaning of the Commerce Clause*, 68 U. Chi. L. Rev. 101 (2001). Even scholars who have taken a broader view of the commerce power find a touchstone in activity. *See, e.g.,* Grant S. Nelson and Robert J. Pushaw, Jr., *Rethinking the Commerce Clause: Applying First Principles to Uphold Federal Commercial Regulations but Preserve State Control over Social Issues*, 85 Iowa L. Rev. 1 (1999) ("the voluntary sale or exchange of property or services and all accompanying market-based activities, enterprises, relationships, and interests"). *See Gibbons v. Ogden*, 22 U.S. at 189–90 ("intercourse").

That limitation on the Commerce Clause is necessarily recognized by the numerous cases describing the commerce power as applicable to "activities." As the Eleventh Circuit has made clear, the commerce power permits Congress to regulate "three categories of *activities*." *Garcia*, 540 F.3d at 1249 (emphasis added). These categories include: (1) "use of the 'channels' of interstate commerce;" (2) using the actual "instrumentalities" of interstate commerce; and (3) "purely intrastate activities when they 'substantially affect' or have a 'substantial relation to' interstate commerce." *Id.* at 1249-1250, citing *Raich*, 545 U.S. at 25, and *Lopez*, 514 U.S. at 558, among other authorities.

Nor does the Individual Mandate regulate a commercial or economic "activity" that substantially affects interstate commerce. While Congress also can regulate certain purely intrastate and local commercial activities under the Necessary and Proper Clause, it still must direct such a regulation to an *existing* commercial activity. *Garcia*, 540 F.3d at 1250 ("intrastate activities"). Defendants have not identified a single case (with the exception of the wrongly decided *Thomas More Law Center v. Obama*, 2010 WL 3952805 (E.D. Mich. Oct. 7, 2010)) even suggesting that the commerce power reaches beyond the regulation of actual economic *activity*.

3. Inactivity Cannot be Redefined as "Economic Activity"

Defendants engage in Orwellian efforts to redefine the inactivity of not having healthcare insurance as an affirmative economic activity of "deciding" not to buy insurance, or deciding *now* how to pay (or not to pay) for potential *future* economic activity in the form of obtaining medical services. These efforts are insupportable by language, law, reason, and precedent. To be "active" in a market, a person must be

selling, buying, producing, transporting, using, or possessing a good or service available in that market. The same is true of both the market for healthcare services and the market for healthcare insurance. There is nothing "unique" about those markets.[5]

If the "decision" not to engage in commerce is an economic activity that may be regulated either as interstate commerce itself, or as having a substantial effect on interstate commerce, then the very notion of "commerce" is empty of meaning and encompasses everything. Under Defendants' theory, all decisions in life can be recast as decisions to forego some alternative economic activities, and therefore fall under Congress's reach. The decision to sleep becomes a decision not to work, and hence an economic activity. The decision to rest on the weekend becomes a decision not to engage in commercial behavior. The decision to go to high school or college becomes a decision to postpone entry into the labor market. As the *Lopez* Court correctly explained, such tortured reasoning "lacks any real limits because, depending on the level of generality, any activity can be looked upon as commercial." *Lopez*, 541 U.S. at 565.

It is no answer to state the obvious point – and one of which the Supreme Court surely has been aware all along in limiting the commerce power to activity – that the absence of consumers, *i.e.*, their inactivity, can have secondary effects on a market. The lack of demand for, *e.g.*, orange juice can impact citrus growers, processors, marketers,

[5] As noted below, one of Defendants' own experts indicates that these two "markets" are, in fact, quite separate and distinct. *See infra* at 22-23. Defendants have not explained how the alleged characteristics of the market for medical services render the market for healthcare insurance different from any other insurance market involving the management of widely-shared significant risks, such as the markets for life insurance or disability insurance.

and sellers, on the supply side; and it can affect prices paid by consumers, on the demand side (depending on how the aggregate supply is adjusted). But these are effects on persons or businesses *who are voluntarily active in the market.* The same can be said of virtually any conceivable market. Inactivity of itself is neither "economic" nor "financial," despite Defendants' claims to the contrary. DMSJ at 27.

Similarly, as with healthcare, the timing of individual entries (and exits) in markets generally, including markets for necessities, is unpredictable and can involve extensions of credit and substantial costs which many consumers, at length, may be unable to pay. Their defaults result in the same "cost-shifting" that Defendants wrongly contend applies solely to healthcare. But cost-shifting takes place among *active market participants*, as losses caused by defaulting consumers are either absorbed by suppliers or passed along to other participants – *all of whom are voluntarily active in the market*.[6]

Moreover, Defendants' absurd claim that anyone without healthcare insurance is "engaged in economic activity to an even greater extent than the plaintiffs in *Wickard* or *Raich*," DMSJ at 29, not only defies language and logic, but also ignores the genuine *activities* regulated in those and other cases. As the Court already has noted with respect to *Wickard v. Filburn*, 317 U.S. 111 (1942) and *Heart of Atlanta Motel v. United States*, 379 U.S. 241 (1964), Congress merely was regulating the economic and commercial activities in which the complainant parties had *chosen* to engage. Mem. Op. at 62-63. In

[6] In this regard, it is worth emphasizing that cost-shifting is ubiquitous in all segments of the modern economy, because of the widespread availability of credit and the increasing rarity of cash payment for goods or services upon delivery. The consequences for the economy in such cases may differ in degree, but not in kind, from those attending the healthcare market.

Wickard and *Raich*, Congress regulated commodities indisputably within its reach, and the parties could have avoided federal regulation through the simple expedient of choosing not to grow, consume, or use the relevant substances.

The same is true of every appeals court case Defendants cite. *See United States v. Ambert*, 561 F.3d 1202, 1211 (11th Cir. 2009) (regulating sex offenders when they "travel[] in interstate or foreign commerce"); *United States v. Gould*, 568 F.3d 459, 470 (4th Cir. 2009) (same); *United States v. Olin Corp*., 107 F.3d 1506, 1510 (11th Cir. 1997) (regulating "the disposal of hazardous waste"); *United States v. Maxwell*, 446 F.3d 1210, 1216–17 (11th Cir. 2006) (regulating "the receipt, distribution, sale, production, possession, solicitation and advertisement of child pornography"); *Alabama-Tombigbee Rivers Coal. v. Kempthorne*, 477 F.3d 1250, 1272, 1277 (11th Cir. 2007) (regulating the "tak[ing]" of endangered fish); *United States v. Belfast*, 611 F.3d 783, 793, 814 (11th Cir. 2010) (punishing violence and use of a firearm); *Garcia*, 540 F.3d at 1252 (regulating "the commercial leasing of cars"); *United States v. Williams*, 121 F.3d 615, 618–19 (11th Cir. 1997) (regulating the obligation to "pay money" in the form of a child support award which "crossed state lines."). In each case, the courts upheld the regulation of an *activity*.

4. Defendants Can Identify No Meaningful Limiting Principle

Defendants' argument leads inexorably to an infinite commerce power and leaves this and other courts with no coherent or judicially manageable doctrine to limit Congress to its enumerated powers, or to preserve some non-redundant purpose for many other parts of the Constitution. If the Commerce Clause is as broad as Defendants claim, it is difficult to imagine any requirement or regulation that would be beyond it. Indeed, under

Defendants' theory, it is inexplicable why the Constitution's Framers found it necessary to enumerate so many other powers to be vested in Congress – for example, the powers to establish uniform laws on bankruptcies, to coin and regulate the value of money, to punish counterfeiting, to establish post offices and post roads, to provide for patents and copyrights, and to define and punish piracy. U.S. Const. Art. I, § 8, cls. 2, 3, 4, 5, 6, 7, 9.

The exercise of these powers (and many more) certainly falls well within the expansive commerce power Defendants posit, and therefore would be redundant or meaningless in light of so broad a commerce power. Such an interpretation of the Constitution is impermissible. *See Marbury*, 5 U.S. at 174 ("[i]t cannot be presumed that any clause in the constitution is intended to be without effect; and therefore such a construction is inadmissible, unless the words require it.").[7] Defendants' entire theory of the case – that individuals who are absent from a market can be regulated by Congress even though they have not voluntarily engaged in any commercial activity – admits of no limiting principle, and Defendants have not identified any.

5. Limiting the Commerce Power to Commercial Activities Is a Necessary Constraint on Congress

Far from "empty formalism," DMSJ at 16, limiting the commerce power to the regulation of activities is necessary to the judicial enforcement of any other limits on

[7] Defendants suggest that the Bill of Rights would remain as some limit on congressional power. DMSJ at 23. This, however, is not the Constitution's design. Congress's authority is limited both by the limited and enumerated nature of its powers, *see, e.g., Lopez*, 514 U.S. at 553 (noting that "limitations on the commerce power are inherent in the very language of the Commerce Clause."), and by the Bill of Rights. Elimination of the constraints inherent in Article I cannot be justified by reference to the continuing existence of those contained in the Bill of Rights. Moreover, Defendants' position would also render any analysis of "rationality" under the Due Process Clause superfluous.

congressional power.[8] It is this most fundamental constraint which keeps Congress's broad authority to regulate interstate commerce from becoming an impermissible general federal police power, and which provides a clear and judicially enforceable limiting doctrine. *Cf. Comstock*, 130 S. Ct. at 1964 ("'Nor need we fear that our holding today confers on Congress a general 'police power, which the Founders denied the National Government and reposed in the States.'") (quoting *United States v. Morrison*, 529 U.S. 598, 618 (2000)).

Like the commercial/non-commercial limiting doctrine set out in *Lopez*, the activity/inactivity line has a long history of practical adherence and recognition. The novelty of Congress's current attempt to escape this prior limit – and hence the dearth of case authority enforcing that limit – confirms its existence and vitality.

6. Only a Forbidden Police Power Could Support the Mandate

Only a forbidden "police power that would authorize enactment of every type of legislation," *Lopez*, 514 U.S. at 566, could support the Individual Mandate.[9] Defendants have no answer to this point. Indeed, their references to other instances in which Congress has imposed "mandates" are as inapposite as the authorities they cite, because

[8] Moreover, as the Supreme Court explained in *New York v. United States*, 505 U.S. 144, 187 (1992), "[m]uch of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measures deviating from that form. The result may appear 'formalistic' in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions."

[9] The ability to regulate individuals based only on their presence in a jurisdiction is, of course, the defining characteristic of a "police power." *Cf. Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (upholding State's right to require an individual's smallpox vaccination simply because he was present in the State).

in those cases Congress relied on *other* enumerated powers, not the Commerce Clause. DMSJ at 32. In each such case, the mandate was grounded in a grant of authority that necessarily included the power to command the service of individuals as a matter of law, logic, and longstanding practice based on the most fundamental attributes of citizenship. *See, e.g.*, *Selective Draft Law Cases*, 245 U.S. 366, 378–79 (1918) (authority to compel service recognized as inherent in the very notion of citizenship and the power to raise and support armies); *In re: Heritage Propane*, 2007 U.S. Dist LEXIS 88933, *4, *7 n.3 (E.D. Tenn. Feb. 6, 2007) ("The right to a jury trial is a fundamental part of the American judicial system," and as a result, "[t]he jury is as much an institution of self government as is the election of public officials. Jury service on the part of citizens of the United States thus has become one of the most important and basic rights and obligations of citizenship.").[10]

The Commerce Clause, by contrast, suggests no such power to dragoon the citizenry into the service of Congress's national policy goals.[11] Certainly, enactment of

[10] *In Re Quarles*, 158 U.S. 532 (1895), cited by Defendants, is inapposite. The case stands only for the proposition that the federal government may provide, through a prohibition on criminal conspiracies, for the protection of witnesses and informants. It does not establish any legally enforceable requirement that a citizen must do anything, much less that the commerce power would allow Congress to impose such a requirement. *Id*. at 535 (analogizing citizen's duty to come forward with evidence of a crime to duty to act as part of the *posse comitatus*). In any case, service in the "posse comitatus" also was a recognized incident of citizenship at the time the Constitution was ratified. *Mejia v. City of New York*, 119 F. Supp. 3d 232, 262 & n.33 (E.D.N.Y 2000). The existence of such authority says nothing whatsoever about the proper scope of the commerce power.

[11] Indeed, Defendants are oblivious to the fact that their argument would fundamentally redefine the nature of federal citizenship, altering the relationship between the federal government and the People and violating a number of constitutional provisions. For an argument that this would violate the Tenth Amendment, *see* Randy E. Barnett,

the Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA" or "Superfund") provides no such precedent. Contrary to Defendants' claims, DMSJ at 30-31, CERCLA only imposes a "mandate" based on various activities, including ownership and possession, related to the disposition of hazardous materials. 42 U.S.C. § 9607(a). The fact that a particular owner may not have caused the relevant environmental damage is irrelevant to questions of liability, but ownership or possession of the source of the damage is relevant – which is why an entire industry providing "environmental audits" has blossomed since Superfund's passage in 1980. Land titles now carry with them obligations that, once title is taken, cannot necessarily be discharged by sale or other disposition of the property. These obligations, however, *can be avoided* by not becoming involved in the disposition of hazardous wastes or by not taking title to property where such wastes may be present.[12]

Finally, the constitutional implications of Defendants' argument are both profound and staggering. Defendants suggest that every individual is a "market participant" because every individual either has used or will use healthcare services at

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Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional, NYU J.L. & Liberty (forthcoming), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1680392.

[12] Eminent domain, also cited by Defendants, likewise is inapposite. Although euphemistically described as a "forced sale" (a term not embraced by the Court in *Luxton v. North River Bridge Co.*, 153 U.S. 525 (1894)), the exercise of the power of eminent domain in fact involves the *taking* of private property for public purposes. *Id.* at 529. It is the land, and not the landowner, that is subject to condemnation and the object of governmental power. *See, e.g., Kelo v. City of New London*, 545 U.S. 469, 483–84 (2005). Similarly, each of the various insurance "mandates" cited by Defendants also is contingent on, and regulates, specific economic activities. DMSJ 30 n.9.

some point in time, making everyone subject to regulation under the Commerce Clause. The foundation of this position, of course, is that no one can avoid this particular market and, once in the market, no one may withdraw. Moreover, while permanently a part of this eternal market, everyone would be subject to regulation, and that regulation would not be limited to an individual insurance mandate. Like the businesses regulated by the Fair Labor Standards Act, individuals could be required to provide benefits and services as Congress deemed appropriate. No one, from birth to death, could avoid being regulated. Like the Individual Mandate itself, such absolute federal power over any aspect of life is unprecedented and insupportable based on the text, history and consistent interpretation of the Constitution.

C. The Mandate Cannot Be Saved by the Necessary and Proper Clause

1. The Individual Mandate Fails under the *Comstock* Factors

As Plaintiffs have demonstrated in Pl.Opp.MTD [Doc. 68] at 33-36 and PMSJ [Doc. 80-1] at 17-23, the Individual Mandate plainly fails every consideration identified by the Supreme Court in *Comstock*, its latest opinion dealing with the Necessary and Proper Clause (albeit not in the context of the commerce power). The Individual Mandate is by no means a "modest" or "narrow" provision; it is not supported by any long "history of involvement" of Congress in compelling the purchase of insurance; it is not the "means for implementing a constitutional grant of legislative authority," as shown below; and it does not "properly account[] for State interests," as shown above. *See Comstock*, 130 S. Ct. at 1962. Instead, the mandate represents an unprecedented intrusion of federal governmental power into Americans' lives, and in effect creates a

general federal police power that is reserved to the States under the Constitution. As a consequence, the Necessary and Proper Clause cannot rescue the mandate.

2. The Mandate Is Not "Essential" to a Larger and Legitimate Regulatory Scheme

The Individual Mandate also cannot be sustained as an "essential" part of some larger and legitimate regulatory scheme. Defendants' reliance on *Raich* in this respect is particularly misplaced. The *Raich* Court upheld Congress's regulation of purely intrastate cultivation, possession, and use of marijuana as being "essential" to its larger scheme to regulate dangerous drugs, entirely eliminating certain of these from the interstate market through the Controlled Substances Act ("CSA"). It did so because these intrastate "*activities*" were the same as those "quintessentially economic" activities regulated on the interstate level by the CSA, reasoning that "prohibiting the intrastate possession or manufacture of an article of commerce is a rational (and commonly utilized) means of regulating commerce in that product." *Raich*, 545 U.S. at 24-26 (emphasis added). Failing to regulate "such a significant segment of the total market would undermine the orderly enforcement of the entire regulatory scheme." *Id.* at 28.

The Individual Mandate does not regulate any activity, economic or otherwise, which could undermine enforcement of another regulatory scheme. Nor does the mandate serve to implement an otherwise legitimate regulation of interstate commerce, as did the recordkeeping requirements upheld as necessary and proper in *United States v. Darby*, 312 U.S. 100, 124–125 (1941). It is, in fact, a measure directly designed to achieve Congress's ultimate end, *viz.*, universal healthcare insurance coverage.

Defendants' assertions that the Individual Mandate was meant to implement

ancillary provisions of the ACA governing the sale and content of healthcare insurance policies, DMSJ 19–20, are insupportable. Those provisions, requiring insurance companies to cover preexisting conditions, regulating premiums, and eliminating lifetime benefit caps, are actually "essential" to implementing the mandate. They make it possible for those with preexisting or chronic conditions to secure and maintain the healthcare insurance coverage *the Individual Mandate requires*.

The ACA's structure, text, and legislative history make this plain. The only congressional findings in Title I of the ACA relate to the "individual responsibility" provision, and those findings state that the provision's primary purpose is to "achieve near-universal coverage." ACA § 1501(a)(2)(D). *Cf.* Remarks by the President at Signing of the Health Insurance Reform Bill, http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill, March 23, 2010 ("And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care."). The other findings, citing other provisions of the Act, are subsidiary to this goal. Indeed, it was the Individual Mandate that Congress identified as "essential" to its legislative purpose, not the two lesser provisions – "guaranteed issue" and "community rating" – that Defendants now assert the Individual Mandate serves to implement. DMSJ 20–21.

This reflects a reality that Defendants do not seriously challenge. With or without the Individual Mandate, "guaranteed issue" and "community rating" still could be

implemented in some fashion as effective commercial regulations.[13] Defendants do not even allege that either provision would operate less effectively or be more difficult to administer in the absence of a mandate, but merely that the lack of a mandate would "amplify incentives" for individuals to engage in cost-shifting. DMSJ 20–21.[14] However, this is a direct consequence *not* of anyone's failure to have insurance, but of Congress's own legislative actions. Absent the mandate, the insurance provisions would not achieve Congress's actual goal of guaranteeing universal healthcare coverage. But that ultimate political goal, however laudatory, is not a legitimate end "within the scope of the constitution" to which the Necessary and Proper Clause may be applied. *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 421).

Upholding the Individual Mandate as "essential" to the ACA's insurance regulations would license Congress to create and expand its own regulatory power through the simple expedient of legislating in such a manner as to create its own "necessity," as a means to obtain sufficient power to achieve its true object. This is the very antithesis of a limiting principle: congressional authority would be restrained only where Congress does not act in the context of a broad regulatory scheme. Under that approach, where Congress does enact a broad regulatory scheme, even one whose goals

[13] This stands in marked contrast, for example, to the situation in *Raich*, where the central provision of the Controlled Substances Act – *viz.*, the prohibition of the production, transport, distribution, etc., of dangerous drugs – would have been rendered wholly inoperative in many instances without the ability to reach intrastate activity.

[14] This point is indistinguishable from the argument rejected in *Lopez* that Congress may "regulate any activity that it found was related to the economic productivity of individual citizens." 514 U.S. at 564. Potentially any action or inaction may affect individuals' incentives; were that alone sufficient to support federal regulation, it would be "difficult to perceive any limitation on federal power." *Id.*

are beyond the reach of its enumerated powers, it would face no limits.

In fact, the Individual Mandate is precisely the type of "evasive legislation" – provisions attached to other legislation (however broad or narrow) as a means of regulating beyond what the commerce power otherwise would support, *see Raich*, 545 U.S. at 46-47 (O'Connor J., dissenting) – which the *Raich* Court acknowledged to be a potential danger, but which it did not find to be present in that case. *See id.* at 25 n.34 ("there is no suggestion that the CSA constitutes the type of 'evasive' legislation the dissent fears, nor could such an argument plausibly be made."). The mandate cannot be sustained as "necessary" or "essential" to the ACA's insurance reforms.

3. The Mandate Is Too Remote from the Insurance Regulations It Supposedly Supports

Even if the mandate were designed to support the ACA's insurance provisions, it would fail. Defendants rest their "economic activity" theory on presumed participation in the market for healthcare services, *not* the market for healthcare insurance that Congress purported to regulate with the Individual Mandate. However, as explained by one of Defendants' own authorities, "[a] common feature of several myths [about healthcare in America] is the conflation of health, health care and health insurance. The three are surely connected, but they are not the same." Katherine Baicker & Amitabh Chandra, *Myths and Misconceptions about U.S. Health Insurance*, 27 Health Affairs w533 (2008) (DMSJ, Ex. 6). Thus, "[u]ninsured Americans who are sick pose a very different set of problems. They need health care, not health insurance. Insurance is about reducing uncertainty in spending. It is impossible to 'insure' against an adverse event that has already happened." *Id.* at w534.

Even if every American were a constant "participant" in the market for healthcare *services*, and surely they are not, that would not make them participants in the healthcare *insurance* market. Indeed, Congress itself sought to justify the Individual Mandate as a means of bringing individuals into the latter market, not to regulate their consumption of services in the former market. *See* ACA §§ 1501(a)(2)(G) ("[b]y significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals"), 1501(a)(2)(H) ("[b]y significantly increasing health insurance coverage and the size of purchasing pools ... the requirement, together with the other provisions of the Act, will significantly reduce administrative costs and lower health insurance premiums").

Thus, any market participation by those subject to the Individual Mandate is at least once removed from Congress's purported regulatory target, the healthcare insurance market. In fact, the mandate is yet several more steps removed from the insurance market regulations which it supposedly supports. Defendants and Congress claim that the mandate will reduce the dangers of "market timing" and "cost-shifting," which are exacerbated by the ACA's new rules on preexisting conditions and lifetime benefit caps. This claim, however, is based upon exactly the type of attenuated chain of effects that was rejected by the *Lopez* Court. *Lopez*, 514 U.S. at 567. *See also Comstock*, 130 U.S. at 1963 (links between challenged statute "and an enumerated power are not too attenuated."). Here, the mandate's support for the ACA's insurance regulations necessarily posits that: (1) everyone will consume healthcare services; (2) some persons

who can afford healthcare insurance will not buy it, to save money; (3) some significant percentage of these persons, when they do fall ill, will not pay for the healthcare services they consume; (4) providers will seek to shift these costs to insurers, and by extension to the healthcare insurance market in general, because the ACA requires insurers to take all comers; (5) requiring all individuals to have healthcare insurance will avoid such cost-shifting sufficiently to reduce premiums. *See* DMSJ at 19-25. This is the sort of reasoning that the *Lopez* Court rejected, and the same result must obtain here.[15]

D. That No Previous Congress Believed the Commerce Power To Support Enactment of Individual Mandates Negates Such a Power's Existence

For more than two hundred years, Congress has understood and accepted the fundamental limits on the commerce power. Before passage of the ACA, no Congress ever had required individual Americans to buy a particular good or service as a supposed regulation of "commerce."[16] Although a statute's novelty does not establish its unconstitutionality, the Court has made clear that the "'absence of power' to do something c[an] be inferred because Congress ha[s] never made an attempt to exercise

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[15] Given the integrated and interrelated nature of the modern market economy, both at the national and even global levels, under the Defendants' logic it would be possible to conflate all manner of markets for the purpose of determining whether an activity being regulated is reachable under the commerce power. This approach, which is insusceptible of any meaningful limiting principle, would contravene the teaching of *Lopez* and *Raich*, in which the Court recognized that intrastate activities only can be regulated if they are not too remote from the interstate activities at issue.

[16] This most certainly was not the case in *Wickard v. Filburn*, as Defendants incorrectly suggest. DMSJ at 29. Filburn only was subject to congressional regulation *because he was voluntarily engaged in the business of wheat farming*. He could have avoided regulation by cultivating some other, unregulated crop to meet his needs. The Individual Mandate offers no such choice.

that power before." Mem Op. at 64-65 (citing *Printz v. United States*, 521 U.S. 898, 905, 907-908, 918 (1997)).[17] The *Printz* Court's statement that if "earlier Congresses avoided use of this highly attractive power, we would have reason to believe that the power was thought not to exist," *Printz*, 521 U.S. at 905, is particularly instructive.

The power to require directly that all Americans obtain a particular good or service, including insurance, might be attractive from Congress's perspective. Yet, for generations, in seeking to achieve various political, economic, and social goals through the commerce power, Congress instead has taken care to restrict itself to utilizing indirect regulations to achieve its ends. It purposely has linked regulations to economic activities in or affecting interstate commerce, even though its broader goals often could have been achieved more directly through a mandate on businesses or individuals.[18]

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[17] According to the Congressional Budget Office ("CBO"), a congressional agency with "the primary duty and function" of advising Congress on "bills authorizing or providing new budget authority," 2 U.S.C. § 602(a), an individual healthcare insurance mandate is unprecedented in two respects: "First, it would impose a duty on individuals as members of society. Second, it would require people to purchase a specific service that would be heavily regulated by the federal government." Robert Hartman & Paul Van de Water, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance*, CBO Memo. Aug. 1994, at 1. Similarly, the Congressional Research Service ("CRS"), a congressional agency charged with "determining the advisability of enacting [legislative] proposals," 2 U.S.C. § 166(d)(1), found it "a novel issue whether Congress may use [the Commerce Clause] to require an individual to purchase a good or service." Jennifer Staman & Cynthia Brougher, *Requiring Individuals To Obtain Health Insurance: A Constitutional Analysis*, CRS Report No. R40725, July 2009, at 3. *See id.* at 6 (distinguishing a mandate from Congress's usual use of its commerce power to regulate those "who *voluntarily* take part in some type of economic *activity*") (emphasis added).

[18] *See, e.g.,* 29 U.S.C. § 212(a) (prohibition on child labor implemented as limitation on shipment of goods in interstate commerce); 15 U.S.C. § 78i(a) (prohibiting "manipulation of security prices" when accomplished "by the use of the mails or any means or instrumentality of interstate commerce" or through a national securities exchange); 21 U.S.C. § 62 (making it unlawful "to ship or deliver for shipment in interstate or foreign

There is no better example of this practice – manifesting Congress's respect for the commerce power's limitations – than the National Flood Insurance Program ("NFIP"), which Defendants incorrectly cite as an example of another individual mandate requiring persons to obtain insurance. DMSJ at 30. According to the United States Geological Survey, "[d]uring the 20th century, floods were the number-one natural disaster in the United States in terms of number of lives lost and property damage. They can occur at any time of the year, in any part of the country, and at any time of the day or night." Charles A. Perry, *Significant Floods in the United States During the 20th Century – USGS Measures a Century of Floods,* Mar. 2000, http://ks.water.usgs.gov/pubs/fact-sheets/fs.024-00.html (last visited Nov. 23, 2010). Economic damage from flooding runs well into the billions of dollars annually. National Weather Service, *Flood Losses: Compilation of Flood Loss Statistics*, http://www.nws.noaa.gov/hic/flood_stats/Flood_loss_time_series.shtml (last visited Nov. 23, 2010).

Congress has acted to ameliorate these losses through the NFIP, established under the National Flood Insurance Act of 1968, as amended, 42 U.S.C. § 4001, *et seq*. As Defendants state, the NFIP includes a "mandate" that certain individuals have flood insurance. However, despite the severe and national scope of the problem, Congress did not impose an individual insurance mandate that all Americans, or all homeowners, or even anyone living in a flood plain must obey on pain of penalty. Acting within its constitutional parameters, Congress required flood insurance *only* as a *condition* of

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commerce" any "filled milk"); 21 U.S.C. § 331(a) (central provision of the Food, Drug and Cosmetic Act prohibiting the "introduction or delivery for introduction into interstate commerce of any food, drug, device, tobacco product, or cosmetic that is adulterated or misbranded").

securing and maintaining a mortgage *from a federally-regulated financial institution*. 42 U.S.C. §4012a(a)(b) & (e). The requirement does not apply to property owners who do not have such mortgages or to anyone else who lives under threat of flooding.

To the extent that Congress wanted to keep those without flood insurance from imposing costs on others, a far more direct regulation would have been simply to require all individuals living in a flood plane to have insurance. But the 90th Congress took the indirect and constitutionally-permissible route, because it understood that the commerce power permits regulation of interstate commerce – including mortgage lending – but not of individual Americans, even if they live in a flood plain. As the *Printz* Court stated, "two centuries of apparent congressional avoidance of the practice ... tends to negate the existence of the congressional power asserted here." *Printz,* 521 U.S. at 918.

II. THE ACA'S MEDICAID TRANSFORMATION IS UNCONSTITUTIONAL

Defendants' request for summary judgment on Count Four of the Amended Complaint likewise must be denied. Defendants fail to controvert any of the key facts upon which Count Four is based. Indeed, Defendants do not contest:

- that the Medicaid program is long-established and critically relied upon by tens of millions of poor and needy residents in the States;
- that the ACA fundamentally transforms Medicaid, and the States' partnership role and financial obligations in the program, in precisely the ways that Plaintiffs contend;
- that Congress, in creating the ACA's very structure, presupposes and depends on the States' inability to walk away from Medicaid;

- that no transitional mechanism exists under law to facilitate an orderly withdrawal from Medicaid by a State so as to avoid jeopardizing the lives and welfare of millions of its poorest and neediest residents; and
- that States' withdrawal from Medicaid would mean the loss of funding from the Nation's single largest grant program – a whopping $251 billion per year comprising 40 percent of all federal outlays to States and averaging 20 percent of States' budgets – while State citizens still would be required through payment of taxes to fund Medicaid programs of participating States.

Instead of meeting the thrust of Plaintiffs' position, Defendants point to how much more the federal government will be spending under the ACA. However, this response is legally irrelevant to whether the Act unlawfully coerces and commandeers the States. Congress simply does not possess an untethered ability to transform Medicaid in any manner that it wishes. If anything, enhanced federal funding underscores the ever-increasing power that the ACA exerts over the States: the more the federal government spends, the more it taxes resources away from residents and businesses of the States; the greater the diversion of local resources to Washington, D.C., the greater the States' need for subsidies from the federal government; and the greater the States' need for such subsidies, the stronger the federal government's position to dictate coercive and arbitrary conditions which the States must accept.[19]

[19] As this Court noted, "if the state plaintiffs make the decision to opt out of Medicaid, federal funds taken from their citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to states that have agreed to continue participating in the program." Mem. Op. at 56.

Defendants then fantastically assert that the Act will *save* the States money. Defendants rely primarily on a pre-ACA report of the President's Council of Economic Advisers ("'CEA"). However, as Plaintiffs' responsive Declarations show, that report is based on demonstrably invalid assumptions, which probably explains why *none* of the federal agencies tasked with assessing the Act's impact – including the CBO, which estimated the net costs to the States to be in excess of $20 billion – even cited it. *See* PRSOMF ¶ 48. Significantly, the CEA report, like Defendants themselves, completely ignores the Act's new requirement that the States (but not the federal government) be responsible for the *provision* of healthcare services, an obligation that could lead to tremendous costs for the States, particularly in light of projected shortages of providers for Medicaid recipients. It also ignores ACA provisions that prohibit States from tightening eligibility requirements – a typical but important way for States to control costs – and, for the first time, prevents them from reducing huge *optional* outlays (comprising 60 percent of States' Medicaid spending). *See* Anna Sommers, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories*, Kaiser Comm'n on Medicaid & the Uninsured, June 2005, at 11.

Moreover, the entire question of whether the States' costs might to some extent be offset by collateral savings is legally irrelevant: regardless, the ACA represents a substantial departure from the Medicaid partnership between the federal government and the States, and imposes heavy new burdens that the States cannot avoid.

Once the preposterous assertion that the ACA will save the States money is swept aside, Defendants are left with rearguing the justiciability of Plaintiffs' claim, an issue already resolved against them by this Court.

Finally, Defendants fail to address that the ACA's overhaul of Medicaid violates every restriction on Congress's spending power under Article I of the Constitution.

A. Defendants Cannot Dispute the ACA's Significant Alterations to Medicaid

As the Supreme Court noted in *Harris v. McRae*, 448 U.S. 297, 301, 308 (1980), "[t]he Medicaid program was created … for the purpose of providing federal financial assistance to States that *choose to reimburse* certain costs of medical treatment *for needy persons*." (Emphasis added.)

The ACA undoes every critical characteristic of the Medicaid partnership between the States and the federal government. Medicaid was enacted to address healthcare needs of the *poor and needy*, but the ACA expands eligibility to all persons whose income is up to 38 percent *above* the federal poverty line. Medicaid was limited to *reimbursing* needy persons' healthcare expenses, but the Act now requires the States (but not the federal government) to *provide* medical care. ACA § 2304.[20] These undeniable changes go far beyond the original Medicaid partnership. In effect, they constitute a new Medicaid regime, imposed in top-down fashion – the antithesis of partnership.

[20] The *Harris* Court, as if anticipating the ACA, warned of federal overreaching of the Medicaid partnership: "Title XIX was designed as a cooperative program of shared financial responsibility, *not as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund*." 448 U.S. at 309 (emphasis added).

It is no answer to say that the States, in entering into their pre-ACA Medicaid programs, agreed that the federal government could amend the programs. The federal-state Medicaid partnership agreement did not afford plenary power to the federal government to make *any* Medicaid revision that it wished irrespective of the States' expectations, or to bully the States with threats to remove them from the program for failing to accept transformative and harmful new conditions. Prior amendments to the States' Medicaid programs involved comparatively modest refinements of eligibility criteria (or optional revisions – again, *60 percent* of Medicaid spending being optional) for the benefit of the poor, young, aged, and infirm populations. Judicial decisions cited by Defendants (DMSJ at 48) have upheld such amendments as they comport with the basic nature of the partnership that States voluntarily entered. The States could foresee these amendments, which were consistent with the well-settled Spending Clause requirement that Congress must not condition funding to the States on ambiguous terms. *See South Dakota v. Dole*, 483 U.S. 203, 207-08 (1987). But those earlier changes are a far cry from the ACA's blanket departure from needy eligibility categories and its substitution of broad income-based eligibility 38 percent above the federal poverty line.

Moreover, the States could not have foreseen that Congress would impose on them the burden of being responsible for providing healthcare services *themselves* rather than merely reimbursing the healthcare costs of the needy. This change exposes the States to massive costs, burdens, and potential liabilities to which they never agreed, and which Congress has refused to share. As Plaintiffs have shown, PMSJ [Doc. 80-1] at 41 n.41 & 42 n.42, a serious shortage of Medicaid providers is projected. This shortage, on

top of ACA's imposed new burden that that the States be responsible for the provision of services, will put the States in a terrible dilemma: either increase their Medicaid expenditures drastically to attract sufficient numbers of providers, or face potentially catastrophic liabilities for widespread failures to furnish needed healthcare services in timely fashion. While this ACA imposition alone could bankrupt the States, none of the government agencies and outside organizations assessing the ACA's overall costs has, to Plaintiffs' knowledge, even ventured to assign a dollar figure for this burden. So glaring an omission surely is not the result of the cost being trivially small; if anything, the omission reflects that the cost is so gargantuan as to defy estimation – which probably explains why the federal government has refused to be co-responsible for this burden.

In addition, while the Medicaid partnership afforded States wide discretion to control various aspects of their programs, the ACA removes this and imposes maintenance-of-effort requirements that punish States by locking in their previously-optional higher spending levels and freezing those levels in place for a prescribed period. *See* Sommers, *supra* (more than 60 percent of Medicaid spending is optional). As with the other changes imposed by the ACA, this elimination of discretion – an important factor to controlling program costs – was not reasonably foreseeable by the States.

In effect, Congress has scuttled the existing Medicaid program in favor of a new program that is vastly different and specially designed to facilitate the ACA's goal of near-universal coverage – a goal wholly distinct from the previous Medicaid objective of helping the needy. Thus, the ACA greatly widens the Medicaid "door" so that a much-enlarged population can pass through it to comply with the Individual Mandate.

The ACA makes no provision for States to continue their participation in Medicaid under its pre-ACA terms. Nor does the ACA make any provision for States either to exit Medicaid or to effect a safe transition from Medicaid that would protect their needy residents. Thus, Congress seeks to use its funding hold over the existing Medicaid partnership to force the States to accept the new Medicaid regime and its obligations and costs. This Hobson's choice is an abuse of Congress's spending power.

B. The ACA's Transformation of Medicaid Harms the Plaintiff States' Budgets and Sovereignty

Defendants argue that the ACA is not coercive because the increased State spending required by the ACA will be small compared to federal spending levels and because the ACA is broadly beneficial. Mem. at 39. Defendants understate the magnitude of the States' Medicaid obligations under the ACA, which they modestly calculate to be 1.4 percent over existing baseline projections, while wholly ignoring (1) the well-documented fiscal emergency in States arising from those same baseline projections of spiraling State Medicaid obligations that threaten their fiscal viability; (2) the dangerous expansion of State obligations that requires States to be responsible for the provision of healthcare services, with a virtually certain massive increase in liability; and (3) the elimination of States' flexibility under Medicaid to control their costs. In sum, the ACA's transformation of Medicaid stands to run State budgets off the proverbial cliff.

1. Plaintiffs' Coercion Claim Is Not Undermined By Increased Federal Spending on Medicaid under the ACA

Defendants boast of substantial increases in federal spending associated with the ACA's Medicaid program in comparison to the relatively "small outlays" required of the

States, DMSJ at 39, but this is no defense to Plaintiff States' coercion claim. As noted above, the States depend on the return to them, through Medicaid grants, of the vast resources taken from their citizens and businesses by the federal government. That the federal government is *increasing* Medicaid outlays under the ACA – on condition that the States accept the new Medicaid regime or lose all Medicaid funding – only strengthens the conclusion that the federal government has made the States an offer they cannot refuse. If ever there were to be a "financial inducement offered by Congress … [that] pass[es] the point at which 'pressure turns into compulsion[,]'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)), *this is it*. The ACA surely represents the very danger that prompted Justice O'Connor, in her dissent in *Dole*, to warn that the "vast financial resources of the Federal Government" could permit Congress under the guise of the Spending Clause "'to tear down the barriers [and] to invade the states' jurisdiction….'" 483 U.S. at 217 (O'Connor, J., dissenting) (quoting *United States v. Butler*, 297 U.S. 1, 78 (1936)).

Protection against undue coercion is especially warranted here, where participation in the ACA's program will harm the Plaintiff States in serious ways. While Defendants belittle the increase in State spending required by the ACA ("just 1.4 percent" over current projected spending, DMSJ at 40), this increase – on top of already spiraling Medicaid spending obligations – threatens the States' fiscal viability and ability to fund other significant priorities. Even before the ACA, Medicaid imperiled State budgets with substantial increased spending projections at an annual average rate of 7.9 percent through 2019 (and 9.9% just in 2009). CMS, *National Health Expenditure Projections*

2009-2019, https://www.cms.gov/NationalHealthExpendData/downloads/ proj2009.pdf, at 1-2 (last visited Nov. 23, 2010). Federal Medicaid officials concede that "[h]igh and increasing Medicaid spending clearly leaves states less able to fund other state priorities." CMS, *Medicaid Spending Projected to Rise Much Faster Than the Economy*, http://www.hhs.gov/news/press/2008pres/10/20081017a.html (last visited Nov. 23, 2010) (quoting Acting CMS Administrator Kerry Weems).

Other federal authorities simultaneously acknowledge the terrible condition of State finances and their large projected budget gaps (currently up to 41 percent in Fiscal Year 2010).[21] Already-increasing Medicaid obligations combined with then-current Medicaid and healthcare induced budget stress left Federal Reserve Chairman Ben Bernanke to conclude that "State budgets will probably remain under substantial pressure for a while, leaving governors and legislatures a difficult juggling act as they try to maintain essential services while meeting their budgetary obligations." Pl.App. Ex. 34 (Bd. of Governors of the Federal Reserve System, *Challenges for the Economy and State Governments*, Aug. 2, 2010) at 6; *see also The Long-Term Budget Outlook*, CBO, June 2010 ("CBO Budget Outlook") at 27, available at http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf (last visited Nov. 23, 2010) ("state governments – which pay a large share of Medicaid's costs and have considerable influence on those costs – will need to reduce spending growth in order to

[21] Pl.App. Ex. 35 (*Policies for Increasing Economic Growth and Employment in 2010 and 2011,* Cong. Budget Off., Jan. 2010) at 13, 16 (figure 4); *see also State Fiscal Conditions & Medicaid,* Kaiser Comm'n, http://www.kff.org/medicaid/upload/7580-06.pdf (including current gaps and those already closed by states, budget shortfalls total $350 billion for 2010 and 2011).

balance their budgets"). According to the federal Government Accountability Office ("GAO"), States must immediately control Medicaid and healthcare costs for many years ahead to prevent operating deficits – calculated to be $9.9 *trillion* from 2009 to 2058 – and persistently cut costs "for each and every year going forward [to achieve] equivalent to a 12.3 percent reduction in state and local government current expenditures." Pl.App. Ex. 38 (*State and Local Governments: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs* (GAO-10-899), GAO, July 2010) at 6.[22] Chairman Bernanke has counseled States to "intensively review the effectiveness of all programs and be willing to make significant changes to deliver necessary services … [which is] especially important in the case of health programs, where costs are growing the most quickly." Bernanke, *supra*, at 12.[23]

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[22] *See also* Pl.App. Ex. 37 (*State and Local Governments' Fiscal Outlook (GAO-10-358)*, March 2010) at 8-9:

> Because most state and local governments are required to balance their operating budgets, the declining fiscal conditions shown in our simulations suggest [that] these governments will need to make substantial policy changes to avoid growing fiscal imbalances.… The primary driver of fiscal challenges for the state and local government sector continues to be … state and local expenditures on Medicaid and the cost of health insurance for state and local retirees and employees.

[23] Another recent report sums up the States' Medicaid fiscal dilemma as follows:

> Medicaid, the $360 billion a year federal-state health program that serves more than 60 million low-income Americans, has emerged as a central factor in the states' budget and financial crisis. But an even more severe crisis looms ahead, given the steady rise in health care costs, together with higher, recession-induced demand for Medicaid benefits, and the end of $103 billion in federal stimulus aid to states by mid-2011.
>
> In the absence of major reforms and a robust economic recovery, the potential consequences of the growing state Medicaid squeeze are substantial, experts say. States may slide deeper into the red, affecting

Thus, even before Congress looked to increase State Medicaid funding by 1.4 percent under the ACA (according to Defendants' modest projections), the States faced a grim fiscal outlook under baseline projections that will continue to require swift and drastic State action. *See* Kaiser Comm'n on Medicaid & the Uninsured, *State Fiscal Conditions & Medicaid,* Feb. 2010, at 3, http://www.kff.org/medicaid/upload/7580-06.pdf (last visited Nov. 23, 2010) ("nearly every state implemented at least one new Medicaid policy to control spending in FY 2009 and 2010 … [and m]id-way through FY 2010, 44 states indicated that they were likely to or there was a possibility of additional Medicaid cuts beyond those planned at the beginning of the state fiscal year"). With State finances in critical condition, and a widespread existing need for States to *cut* their Medicaid costs, Defendants' attempt to pass off increased State outlays as "relatively small" and insignificant is disingenuous: "It's like living in a parallel universe, … [o]n the one hand, we have federal partners talking about expansion of this program. And at the state level, we're looking at a program that we can't sustain." Janet Adamy, *Medicaid Stalemate Tests Cash-Strapped States*, Wall. St. J., July 13, 2010 (quoting a Medicaid official in one of the Plaintiff States).

> bond ratings and making it more difficult for them to borrow. Deep cuts in kindergarten through grade 12 and higher education spending could make recent teacher layoffs seem relatively trivial. Sharp state tax and user fee increases may be inevitable. Even some anti-big government conservative governors may be forced to seek additional federal aid. And health care for the poor — the basic function of Medicaid — may suffer.

Andrew L. Yarrow, *State Budget Crises Mount as Medicaid Rolls Soar,* The Fiscal Times, Sept. 8, 2010, *available* at http://www.kaiserhealthnews.org/Stories/2010/September/08/FT-states-budget-crisis-medicaid.aspx (last visited Nov. 23, 2010).

In sum, the ACA's Medicaid program stands to harm the Plaintiff States substantially, despite Defendants' contention that it offers a good deal to the States.

2. Increases in State Spending Will Not Be Offset By New Savings Under the ACA

Defendants next make incredible claims that State costs will be more than offset by savings under the ACA. They would have this Court discount documented costs to the States from the ACA (which Defendant do not deny, see DSOMF ¶¶ 40, 47) in favor of indefinite and inaccurate projections of countervailing State savings drawn from an unsworn analysis from the Executive Office of the President, Council of Economic Advisers, that was released months prior to anyone knowing the ACA's final terms, during the intense campaign for passage of a comprehensive healthcare bill.[24]

As the sworn declarations from several Plaintiff States' Medicaid agency representatives show, the CEA report's analysis has serious flaws that render Defendants' savings claims not only unestablished, but unbelievable. PRSOMF at ¶¶ 48-57. For instance, Defendants boldly assert that "Florida alone is projected to save $377 million per year." DMSJ at 41. But the CEA report upon which Defendants exclusively rely actually shows that virtually none of the "savings" applies to the State of Florida:

- Most of the claimed "savings" – more than $256 million – applies to local governments only, not to the budget of the State of Florida: $187 million for Miami-Dade County, $82 million for Hillsborough County, $660,000 in Duval County, and $5.6 million relating to inter-county reimbursements. *See* CEA report at 24, 26. The State of Florida will not see *any* savings from these local

[24] CEA Chair Christina Romer deemed herself "the most passionate person for health care reform in the entire White House." *Romer on Health Care Costs: "The Nightmare Scenario is Getting Closer*," June 2, 2009, http://blogs.abcnews.com/politicalpunch/2009/06/romer-on-health-care-costs-the-nightmare-scenario-is-getting-closer.html (last visited Nov. 23, 2010).

government programs financed through local taxes, though the State may see cost *increases* as persons switch out of such local programs to Medicaid.

- The CEA report's "Hidden Tax" ($102 million) figure (pp. 6, 24) erroneously assumes that the healthcare bill will eliminate uncompensated care altogether. This figure is fatally flawed as Defendants admit, for instance, that 55 percent of current uninsured persons under the federal poverty line will remain uninsured in Florida, DMSJ at 39, and 21 million nationally. *See Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act*, CBO, April 22, 2010. The CEA report also bases this estimate on costs borne by both State *and local* governments, and so it is inaccurate in any event to attribute the full $102 million savings estimate to the State of Florida alone.

See Pl.Supp.App. Exs. 4 (Further Dudek Decl.) & 5 (Pridgeon Decl.). The CEA report also understates costs by relying on the increase for Medicaid eligibility to 133 percent above the poverty line, when in fact the ACA as amended raises that criterion to 138 percent, thereby adding millions more Medicaid recipients to States' rolls. *See* Pl.Supp.App. Ex. 1 (Chaumont Further Decl.) ¶ 17 & Ex. 3 (Damler Decl.) at ¶ 11.

In addition, the CEA report forecasts State savings (of $117 million) that "may come" from the Children's Health Insurance Program. CEA report at 24-25. But Florida, for example, already has taken State CHIP-related savings projections into account in its own forecast (*see* Pl.App. Ex. 1 (Dudek Decl.) at ¶ 20, wherein Florida estimates the ACA will cost it more than $1 billion annually by 2018-19; *see also* Pl.Supp.App. Ex. 1 (Chaumont Further Decl.) at ¶ 13).

It is no wonder that the CEA report is not even cited by government agencies in their assessments of projected costs from the ACA. *See, e.g.*, Pl.App. Ex. 39 (Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act,"* Centers for Medicare & Medicaid Servs., April 22, 2010); Pl.App. Ex. 36 (*Variation in*

Analyses of PPACA's Fiscal Impact on States, Cong. Res. Serv., Sept. 8, 2010) at tbl 2; Def.App. Ex. 32 (CBO Letter to Speaker Pelosi).

Moreover, Defendants' "savings" projections entirely overlook other potentially significant additional costs to the States – most dramatically, costs and liabilities from being required to provide (rather than reimburse the cost of) healthcare services. However, CMS has indicated that it is "probable initially" that there will be fewer healthcare providers accepting Medicaid patients:

> [I]t is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years. … For now we believe that consideration should be given the potential consequences of a significant increase in demand for health care meeting a relatively fixed supply of health care providers and services.

Pl.App. Ex. 39 (*Estimated Financial Effects of the [ACA]*, CMS) at 20. The ACA shifts this problem entirely to the States for them to bear the costs and legal consequences of a programmatic failure that the federal government thoroughly foresees. This, added to the general projection of a looming serious doctor shortage, puts the States in an untenable dilemma: either (1) increase their Medicaid outlays substantially in the hope of attracting sufficient numbers of providers to furnish all needed services to Medicaid recipients, or (2) face the consequences for failing to meet this ACA requirement, including potential massive liabilities and loss of Medicaid funding. Any claim of net "savings" that ignores such catastrophic consequences is seriously misleading and should be disregarded.

Beyond all of these categories overlooked by Defendants, CRS recognizes that the ACA could increase States' costs in the following areas:

- State requirement to maintain existing Medicaid and CHIP eligibility levels (MOE) for adults until exchanges are fully operational (presumably CY 2014) and

for children through 2019 as a condition of receiving federal matching funds for Medicaid expenditures;

- State requirement to improve outreach, streamline enrollment, and coordinate with CHIP and proposed exchanges that may increase applications and enrollment among those previously eligible but not yet enrolled, as well as increase administrative costs in the short run (*see* PRSOMF ¶ 41 n.3 & n.4);

- Federal requirement to reduce Medicaid disproportionate share hospital (DSH) allotments. While the healthcare reform law is designed to lower the number of low income patients and patients whose care otherwise would be funded in part by DSH payments to hospitals treating such patients, the ACA's requirement to reduce DSH payments going forward may necessitate increased outlays by States to shore up hospitals against losses;

- Federal requirement to increase the amount of Medicaid drug rebates going to the federal government. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the HHS Secretary on behalf of states. Beginning January 1, 2010, with certain exceptions, the ACA increases the flat percentage used to calculate Medicaid's basic rebate by an amount that varies by drug class. The ACA also requires the Secretary to recover the additional funds States received from drug manufacturers due to increases in the basic Medicaid rebates (some of which were previously retained by States).

Pl.App. Ex. 36 (*Variation in Analyses*, CRS) at 4-5; see also PSOMF ¶¶ 15, 21, 24-27.

In sum, the notion that the States could achieve net savings under the ACA is both unsupported and preposterous. *See* PRSOMF ¶¶ 57-58 (disputing two other papers that Defendants cite in passing in DMSJ at 41 n.12). No credible assessment of the ACA's projected impact forecasts any such thing. And, as noted, none places a dollar value on the ACA's requirement that States provide healthcare services under the new Medicaid regime, or on the harm to State budgets from the ACA's maintenance-of-effort provisions that remove their ability to cut costs by revising (formerly) optional eligibility categories.

Moreover, even if the States were projected to achieve collateral savings, those savings would in no way lessen the coercion and commandeering of which Plaintiff

States complain, because they still would be required to do Congress's bidding, and to incur costs and liabilities under the ACA's new Medicaid regime, as noted above.

C. Plaintiffs States' Coercion Claim Is Justiciable and Fit for Judicial Resolution in Plaintiffs' Favor

Their other contentions unavailing, Defendants rehash their argument that coercion claims are nonjusticiable. However, this Court already has analyzed Defendants' argument and the viability of the coercion doctrine, and concluded that the Plaintiff States' claim is not foreclosed in this circuit or by Supreme Court precedent:

> If the Supreme Court meant what it said in *Dole* and *Steward Machine Co.* (and I must presume that it did), there is a line somewhere between mere pressure and impermissible coercion. The reluctance of some circuits to deal with this issue because of the potential legal and factual complexities is not entitled to a great deal of weight, because courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court. … [T]he plaintiffs have stated a "plausible" claim in this circuit.

Mem.Op. at 56-57.

Moreover, as recently as 1999, the Supreme Court acknowledged the viability of coercion claims based on financial inducement in a case that closely divided on the question of whether a federal act unlawfully could "coerce" a State to waive its sovereign immunity as a condition of pursuing lawful activity. *Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999). Although *College Savings Bank* did not involve financial inducement, the Court noted that where Congress threatens to withhold "substantial" funds unless a State agrees to its conditions, "'the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* (quoting *Dole*, 483 U.S. at 211, and

Machine, 301 U.S. at 590). Thus, this Court again should reject Defendants' argument that coercion claims are nonjusticiable.

Defendants add a divide-and-conquer argument that the ACA-transformed Medicaid program might be coercive for some States, but not for others. DMSJ at 44-45. Of course, federal bullying of less-populated States (Defendants attempt to peel off, for instance, Alaska and Wyoming) with the "single largest Federal grant-in-aid program to the States, accounting for over 40 percent of all Federal grants to States"[25] still would constitute unlawful coercion. Even though the nature and scope of Medicaid programs and funding differ according to States' policies, sizes, and priorities, federal support for the Medicaid programs in all States is quite substantial, amounting to hundreds of millions or billions of dollars annually in State budgets and averaging more than *20 percent* of total State spending nationally.[26]

Moreover, it is no answer that State Medicaid spending levels in the Plaintiff States fall at different places on a "substantial impact continuum" from 8.4 percent of Alaska's total State spending to more than 30 percent of Pennsylvania's. In either case, and for all States in-between, Congress's threat to withhold significant percentages of State funding easily meets and exceeds the unlawful financial inducement threshold. That is, the threat to exclude citizens in any State from this enormous program –

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[25] Bipartisan Comm'n on the Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005); *see also* Pl.App. Exs. 32-33 (CMS letters to Arizona).

[26] *See* http://www.statehealthfacts.org/comparereport.jsp?rep=45&cat=17 (last visited Nov. 23, 2010); http://www.hhs.gov/recovery/statefunds.html (last visited Nov. 23, 2010) (more than $15 billion additional federal Medicaid dollars were distributed to the States in 2009).

consuming some seven percent of *all* federal outlays ($251 billion in 2010)[27] and funded with federal taxes paid by citizens from all States – would constitute unlawful coercion even for a State that spends comparatively less of its budget on Medicaid.

Regardless of which State is considered, federal Medicaid funding dwarfs the $4 million in highway grant funds at stake in *Dole* that the Supreme Court found to be merely "mild encouragement." 483 U.S. at 211. Indeed, the Medicaid program dangles total funding that is *twelve times higher* than the amounts that Justice Breyer and three other justices considered "compelling and oppressive" in *College Savings Bank.* 527 U.S. at 697 (Breyer J. dissenting) (suggesting coercion with respect to $20 and $21 billion programs). Thus, whatever quibbles Defendants have as to exactly how large a lesser financial inducement must be to trigger application of the coercion doctrine need not be resolved here, because Medicaid is not a marginal spending program. The ACA coerces States with the single largest federal grant-in-aid program to the States.

The unprecedented financial coercion apparent in the ACA's unilaterally transformed Medicaid program, combined with the absence of a defined mechanism for States to exit the program (discussed further below), establishes the Plaintiff States' coercion claim and forecloses summary judgment for the Defendants.

D. <u>The ACA's Medicaid Program Is Unlawfully Coercive</u>

Defendants' final argument also essentially restates their view that coercion claims are nonjusticiable, citing to those circuit court decisions that have so ruled. DMSJ at 47-50. Defendants assert that the size of a federal grant does not matter, the proportion

[27] *CBO Budget Outlook* at 30; Citizen's Guide to the Federal Budget, http://www.gpoaccess.gov/usbudget/fy01/guide02.html (last visited Nov. 23, 2010).

of federal funding does not matter, and the importance of the federal grant does not matter; in sum, and contrary to this Court's prior ruling, they believe that a State cannot establish an unlawful coercion claim on any set of facts. Defendants' citation to *Steward Machine* does not help their argument, as that case did not involve direct and drastic consequences for State budgets, but only encouragement for States to administer an unemployment compensation program funded by taxes on employers. Moreover, *Steward Machine* involved a wholly new program and decision for the States, and not Congress's strategic transformation of a large and long-established program to force States into making a destructive Hobson's choice affecting millions of needy recipients.

Here, Plaintiff States must either accept the ACA's radically changed Medicaid, or (1) forgo billions of dollars annually, which the federal government collects from State taxpayers and then returns as Medicaid funds to the States; and (2) risk the welfare of their most vulnerable citizens, and the continuing vitality of their healthcare infrastructure, by attempting to opt out of Medicaid without any defined transition process or established programmatic alternative. No federal program besides Medicaid funds healthcare services for the States' poorest and neediest residents, and the States plainly are unable to establish, fund, and implement a Medicaid-like replacement program, much less to do so immediately to safeguard needy Medicaid recipients dropped by the federal program.

The prospect of losing these vast sums coerces Plaintiff States not only because of the unprecedented funding levels at stake, but also because Congress has deprived Plaintiff States of the ability to replace their current Medicaid programs. As noted, the

Court has identified this critical aspect of the ACA's program: the federal government "has little money except through taxpayers, who almost exclusively reside within the states," and if federal Medicaid funds are withheld the tax revenues collected in the States who opt out will be diverted to other, more compliant States. Mem.Op. at 56.

Plaintiff States cannot make up this shortfall. In particular, they cannot simply raise State taxes as Defendants suggest in citing *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989).[28] DMSJ at 47. In Florida, as an example, State tax collections in 2009 totaled less than $32 billion, whereas IRS collections from Florida were $110 billion.[29] In 2010, Florida will spend more than $20 billion on Medicaid, toward which the federal government is expected to return to Florida more than $12 billion.[30] For Florida now to opt out of Medicaid and itself provide the same $20 billion in benefits would consume *more than half* of its tax revenues (up from 19 percent currently), not counting the significant costs associated with administering such a program.[31]

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[28] Indeed, federal policymakers suggest that raising State tax increases would only compound the States' fiscal dilemma, and provided federal aid for the *very purpose* of keeping the States from raising taxes. *See* Christina D. Romer, *Back to a Better Normal: Unemployment and Growth in the Wake of the Great Recession*, Council of Economic Advisors, April 17, 2010 at 9, *available* at http://www.whitehouse.gov/sites/default/files/rss_viewer/back_to_a_better_normal.pdf (last visited Nov. 23, 2010).

[29] *See* http://www.census.gov/govs/statetax/0910flstax.html (last visited Nov. 23, 2010); http://www.irs.gov/taxstats/article/0,,id=206488,00.html (last visited Nov. 23, 2010).

[30] *See* Pl.App. Ex. 4 (Leznoff Decl.).

[31] CMS requested $725 million for 2011 to administer Medicaid and other programs. *See* CMS, *Justification of Estimates for Appropriations Comm.*, FY 2011, at 28-29, https://www.cms.gov/PerformanceBudget/Downloads/CMSFY11CJ.pdf (last visited Nov. 23, 2010).

Replacing these revenues would necessitate unfathomable State tax increases (more than 50 percent in Florida), from populations which must continue to pay federal taxes. This alone sets this case far apart from any previous coercion claims rejected by various circuit courts, and exceeds even the "compelling and oppressive" scenarios outlined by Justice Breyer in *College Savings Bank*.[32] Moreover, there are both practical and legal constraints on Florida's ability to raise additional revenue of the magnitude required to replace federal Medicaid payments to the State. *See* Pl.App. Exs. 4 (Leznoff Decl.) & 5 (Watkins Decl.).

Unlike any of the cases cited by the Defendants, these weighty and incontestable constraints unlawfully force the Plaintiff States to participate in the ACA's new Medicaid regime, and to assume billions of dollars of unaffordable new costs and other costly responsibilities against their will. In subjecting Plaintiff States to this unprecedented Hobson's choice, Congress has exceeded its Article I powers and violated fundamental principles of federalism, the Ninth and Tenth Amendments, and the Guarantee Clause. The illusory "choice" offered to the States goes far beyond the point at which persuasion becomes coercion under *Dole*. Congress, having made captives of the States,

[32] Nor is debt-financing of recurring expenses a sustainable option for enabling States that opt out of Medicaid to provide comparable services without federal funding. "Most states have already borrowed as much as they can under their own budget rules and will probably remain up against those limits during the next few years." Pl.App. Ex. 35_ (CBO, *Policies for Increasing Economic Growth and Employment in 2010 and 2011,* Jan. 2010) at 13, 16 (figure 4). As Federal Reserve Chairman Ben S. Bernanke notes: "the balanced budget rules followed by 49 of the 50 states … provide important discipline and are a key reason that states have not built up long-term debt burdens comparable to those of many national governments." Pl.App. Ex. 34 (*Challenges for the Economy and State Governments*) at 6.

impermissibly commandeers Plaintiff States into funding and administering a new federal program contrary to *New York v. United States*, 505 U.S. 144 (1992), and *Printz*.

E. The ACA Violates All Five *Dole* Spending Clause Restrictions

Moreover, imposition of the ACA's Medicaid regime on the States violates all restrictions on Congress's Article I, section 8 spending power under *Dole*, 483 U.S. at 207-08.

First, the Hobson's choice imposed on the States – to give way to federal dictates or attempt to withdraw from Medicaid – cannot reasonably be characterized as furthering the general welfare. Either way, the States' ability to aid the poor will be impaired, because their participation in the ACA-altered Medicaid program threatens to leave them without the resources to provide medical care to indigents, while withdrawal would leave no federally-funded indigent care program at all, and the States alone cannot afford to offer Medicaid-level benefits.

Second, Congress did not condition Medicaid funds on unambiguous terms: the ACA's sweeping changes could not reasonably have been foreseen by the States when they started their Medicaid programs or later chose to add costlier optional elements.

Third, the ACA's altered and expanded conditions – a critical component of a new universal healthcare regime – change the fundamental purpose for which Medicaid was established: *viz.*, as a means to aid the States' poorest residents.

Fourth, the ACA violates State sovereignty and federalism principles, as shown.

Fifth, the ACA unlawfully coerces the States, for all the reasons discussed above.

Because the ACA exceeds every restriction on Congress's spending power, Defendants' claim for summary judgment in their favor on Count Four must be denied.

III. THE ACA MUST BE STRUCK DOWN IN ITS ENTIRETY

The Individual Mandate cannot be severed from the ACA's other provisions. It is the centerpiece of Congress's effort to provide for universal national healthcare insurance, DMTD [Doc. 55-1] at 5, 7, 46-48, and Congress clearly would not have enacted the ACA without the mandate. Based on the statute's text, history, and legislative purpose, without the Individual Mandate Congress "would have preferred ... no statute at all[.]" *Ayotte v. Planned Parenthood of No. New England*, 546 U.S. 320, 330 (2006).

And, of course, it is highly significant that Congress, in crafting one of the most sweeping federal statutes in decades, did not include a severability clause in the ACA. Although the absence of such a provision does not bind the Court, *see, e.g., Alabama Power Co. v. U.S. Dept. of Energy*, 307 F.3d 1300, 1308 (11th Cir. 2002), in this case it strongly suggests that Congress would not "have preferred what is left" of the Act without the Individual Mandate. *See Ayotte*, 546 U.S. at 330. *Cf. Brockett v. Spokane Arcades*, 472 U.S. 491, 506 (1985) (citing severability clause as an important factor favoring partial rather than facial invalidation of statute).

Likewise, the ACA's Medicaid regime constitutes one of four "doors" through which an individual may pass to obtain qualified coverage in order to comply with the Individual Mandate. Hence, the Medicaid regime is essential to the Act's architecture: remove it, and there is no provision for the Nation's tens of millions of poor and needy

persons to comply with the mandate. Because the Act cannot function independent of its Medicaid provisions, those provisions cannot be severed. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684-86 (1987); *Hill v. Wallace*, 259 U.S. 44, 70 (1922). It is therefore unreasonable to infer that Congress would have passed the ACA in the absence of its Medicaid provisions. *See Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 330-32 (2006). Consequently, the unconstitutionality of the Act's Medicaid regime requires that the entire ACA be struck down.

Conclusion

For all the reasons stated above, Defendants' motion for summary judgment should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on this 23rd day of November, 2010, a copy of the foregoing Plaintiffs' Memorandum in Opposition to Defendants' Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

/s/ Blaine H. Winship
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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

SUPPLEMENTAL APPENDIX OF EXHIBITS IN SUPPORT OF PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs hereby submit this Supplemental Appendix of Exhibits in Support of Plaintiffs' Memorandum in Opposition to Defendants' Motion for Summary Judgment.

Respectfully submitted,
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CERTIFICATE OF SERVICE

I hereby certify that, on this 23rd day of November, 2010, a copy of the foregoing Supplemental Appendix of Exhibits in Support of Plaintiffs' Memorandum in Opposition to Defendants' Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

/s/ Blaine H. Winship
Blaine H. Winship
Special Counsel

TABLE OF EXHIBITS

Exhibit No.

Exhibit 1

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

STATE OF FLORIDA, by and through
Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
et al.,

Defendants.

FURTHER DECLARATION OF VIVIANNE M. CHAUMONT

Pursuant to 28 U.S.C. § 1746, I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. My name is Vivianne M. Chaumont. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration.

2. I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program which is subject to requirements of state and federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 906; Title XIX, 42 USC 1396a, et seq.

3. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et*

al., a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

4. I earlier provided an affidavit in this matter describing the impact the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) would have on the Nebraska Medicaid program. That impact was analyzed by Milliman, Inc., an actuarial firm specifically retained by Nebraska DHHS for that purpose.

5. Since providing the aforementioned affidavit, Milliman has provided an updated written analysis of the impact of that federal law as it pertains to DHHS and the State's Medicaid program. A true and correct copy of the updated version of the report, with revised analysis, is attached and marked as Exhibit A.

6. The updated written analysis provided by Milliman was necessitated by a September 28, 2010 letter from the Centers for Medicare & Medicaid Services to state Medicaid directors, which revised previous instructions concerning the federal offset of Medicaid prescription drug rebates.

7. Based upon Milliman's updated written analysis and Nebraska DHHS records and projections prepared and maintained in the regular course of state business, I estimate that the PPACA will cost Nebraska

between $458.2 million and $691.5 million for the period of Fiscal Year 2011 through Fiscal Year 2020. See Exhibit A.

8. I have reviewed Defendants' claim that the PPACA will save the State of Nebraska $36 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

9. The State of Nebraska does not stand to save $36 million due to the savings elements described in the CEA report.

10. Defendants erroneously attribute savings by local governmental units to the State of Nebraska. CEA Report at 67-68. On the contrary, any savings realized by local governments from persons who newly enroll in Medicaid would actually increase costs for the State of Nebraska.

11. The CEA Report upon which Defendants rely also erroneously assumes the elimination of uncompensated care in Nebraska in the amount of $8.6 million ("Hidden Tax" estimate), CEA Report at 68, which is contrary to any known projections familiar to Nebraska DHHS. The CEA Report also bases this estimate on costs borne by both state *and local* governments. As a result, it is not accurate to attribute the full $8.6 million savings estimate to the State of Nebraska alone.

12. The CEA Report's "Hidden Tax" estimate is also likely overstated for another reason. Hospitals which report higher than average (disproportionate share (DSH)) uncompensated costs are eligible to receive

payments to help defray those costs, if they otherwise qualify. As a result, part of this uncompensated care for the uninsured is currently being paid through the DSH program, which includes state and federal funding. Not all of the cost is absorbed into the higher premiums referenced in the CEA Report's "Hidden Tax" section. The DSH program will be phased out over time as uncompensated costs go down. However, there is no assurance that the higher employee health insurance premiums will be going down. Likewise, the CEA Report says that there "may" be increased enrollment that will "potentially" allow cost savings to the states.

13. The CEA Report upon which Defendants rely forecasts that additional savings "may come" from the Children's Health Insurance Program. CEA Report at 68. However, under the PPACA, no changes to eligibility regarding CHIP can be made until 2019. The current eligibility level for CHIP in Nebraska is 200%, which is higher than the 133% provided by the PPACA. There is no mechanism in place for the State to manage or reduce this cost.

14. The $36 million figure relied on by the Defendants from the CEA Report also is based upon the federal government's provision of a 100% FMAP (CEA Report at 6, 70). As passed, however, the ACA does not provide for an indefinite 100% FMAP, but a federal contribution that decreases to 90% by 2019.

15. The CEA Report also states that the State of Nebraska and local governments spend at least $36 million on care for the uninsured, and estimate that the annual cost of Medicaid expansion to Nebraska's low income uninsured individuals would be $178 million, with Nebraska's share being approximately $18 million. However, the CEA Report bases its $178 million estimate on the number of low income uninsured individuals expanding equal to 55,345.

16. Based upon the updated analysis of Milliman, the number of low income uninsured individuals is likely to expand by far more than 55,345, as the CEA Report assumes. Instead, Milliman's analysis takes into account individuals who have the potential to enroll and estimates that enrollment will be at least 107,903 individuals, and possibly as high as 145,297 individuals (see Exhibit A), thus raising the cost to Nebraska.

17. Finally, the CEA Report bases its conclusions on income levels of 133% of the federal poverty line, not 133% with a 5% disregard, as included in the PPACA. As a result, the CEA Report does not reflect the current eligibility levels contemplated by the PPACA.

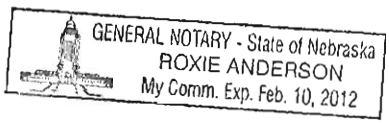
I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and

as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services
Date: 11/22/10

Subscribed and sworn to before me this 22nd day of November, 2010.

Notary Seal



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November 10, 2010

Ms. Vivianne Chaumont, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services
State of Nebraska
P.O. Box 95026
Lincoln, NE 68509-5026

RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE RECONCILIATION – FINANCIAL ANALYSIS - UPDATE

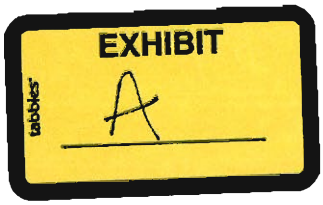
Dear Vivianne:

Milliman, Inc. (Milliman) has been retained by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (DHHS) to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Affordable Care Act) as they relate to the provisions impacting the State's Medicaid program and budget. This letter reflects an update to our analysis reflecting the instructions for the Federal offset of Medicaid prescription drug rebates, as outlined in the September 28, 2010 letter from Department of Health and Human Services October 2010 update to State Medicaid Directors.

SUMMARY OF RESULTS

Milliman has developed two estimates of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. We have developed (1) a mid-range participation scenario and (2) a full participation scenario. We have prepared our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020. We have adjusted all data to reflect the three month offset between the federal fiscal year and the state fiscal year as appropriate.

Enclosures 1 and 2 provide the fiscal impact results of the Affordable Care Act under a mid-range participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the Nebraska Medicaid budget during the next 10 years would be estimated to be in the range of approximately $458.2 million to $691.5 million based upon the assumptions outlined in this document. Table 1 illustrates the anticipated expenditure impacts to the Nebraska Medicaid budget for the period of SFY 2011 through SFY 2020 under each scenario.



Milliman

Table 1

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
4
Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

State Budget Fiscal Impact – SFY 2011 through SFY 2020
(Values Illustrated in Millions)

Component	Estimated Fiscal Impact – State Only	
	Mid-Range Participation Scenario	Full Participation Scenario
Adults and Parents Expansion to 138% FPL	$179.3	$250.6
Children – Enrollment due to ACA	285.8	366.7
Administration	82.4	106.8
Pharmacy Rebate Loss for Nebraska	0.0	0.0
Physician Fee Schedule Increase to Medicare Rates	0.0	56.8
Foster Children Coverage to Age 26	15.1	15.1
Medically Needy Expansion to 138% FPL	5.6	5.6
DSH Reduction	(18.8)	(18.8)
CHIP Enrollment Shift and FMAP Increase	(30.9)	(30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL	(60.5)	(60.5)
Total	**$458.2**	**$691.5**

Note: Values have rounded

The results shown in Table 1 and the enclosures vary from our August 16, 2010 letter due to the impact of the pharmacy rebate loss being removed based on recent guidance from CMS. The Children population has also been shown separately from the Adult and Parent populations.

Estimated Medicaid Enrollment Impact

Table 2 illustrates the projected increase in Medicaid enrollment reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The values in Table 2 were derived from the 2009 Current Population Survey (2009 CPS) data from the U.S. Census Bureau collected in 2009 (representing 2008 insurance and income data) as well as Medicaid enrollment data provided by DHHS. Children were defined as ages 0 through 19. The Adult and Parent populations were defined as ages 20 through 64.

Table 2

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

State Budget Enrollment Impact – 2009 CPS Census Data

Population	FPL Range	Enrollment Full Participation Scenario	Mid-Range Participation Assumption	Enrollment Mid-Range Participation Scenario
Uninsured Adults	0% - 138%	36,779	80%	29,423
Newly Eligible Parents	50% - 138%	20,510	85%	17,433
Woodwork Parents	< 50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers – Adults	0% - 138%	23,916	50%	11,958
Insured Switchers – Parents	0% - 138%	21,429	75%	16,071
Insured Switchers – Children	0% - 138%	14,538	75%	10,903
State Disability (1)	0% - 138%	154	DHHS 133% FPL Assumption+ 5%	154
Medically Needy (2)	43% - 138%	229	DHHS 133% FPL Assumption +5%	229
Sub-total		145,297		107,903

Notes: (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.
(2) Enrollment reflects FPL expansion estimated as of 2014.

The mid-range participation rates in Table 2 were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

Percentage increase in Medicaid in relation to the total number of Nebraskans

- Calendar Year 2008 Nebraska Census Estimate 1,783,000
- Increase would be approximately 6.1% to 8.2% more Nebraska residents on Medicaid
- Increase from 11.6% to range of 17.7% - 19.8% - or nearly 1 in 5 Nebraskans

The remainder of this letter discusses each of the Medicaid components of health care reform as listed in Table 1.

a. Adults/Parents/Children Expansion to 138% FPL

The fiscal impact associated with the Adults, Parents, and Children expansion to 138% FPL includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The analysis presented in this report reflects full participation (full participation scenario) as well as an alternate participation assumption (mid-range participation scenario). The participation assumptions by population are presented in Table 2. The assumed average annual cost per enrollee by population as of State fiscal year 2009 is provided in Table 3.

Table 3

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

Average Cost per Enrollee as of SFY 2009

Population	Average Annual Cost
Uninsured Adults	$5,467
Newly Eligible Parents	$4,881
Woodwork Parents	$4,881
Woodwork Children	$2,654
Insured Switchers – Adults	$5,900
Insured Switchers – Parents	$5,268
Insured Switchers – Children	$2,950
State Disability (1)	$78,107
Medically Needy – Disabled (1)	$85,390
Medically Needy – Long-Term (1)	$109,932

Notes: (1) State Disability and Medically Needy costs provided by DHHS for FFY 2014.

The cost estimates for the State Disability and Medically Needy populations were obtained from the health care reform projection provided by DHHS. All other annual cost estimates were developed from SFY 2009 enrollment and expenditures provided in the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 with appropriate adjustments. The values in Table 3 reflect the age/gender mix of each population based upon the 2009 CPS census data. For example, the insured switcher adult population does not have the same age distribution as the uninsured adult population which impacts expected average cost. Milliman additionally used internally available data from other Medicaid expansion analyses to develop the cost relationship between adults and parents. Milliman assumed a composite annual trend of 3.0% to project the claim cost for the expansion population into future years. The 3.0% trend reflects the impact of enrollment growth as well as projected trend for utilization and intensity of services.

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

Milliman assumed that the projected FFY 2012 FMAP rate of 57.64% for Medicaid and 70.35% for CHIP would continue through 2020 for non-expansion populations.

b. Administration

In addition to the expenditures associated with providing medical services, Nebraska will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be $25 million (State and Federal) or $12.5 million (State only). On-going costs for the coverage of the additional 108,000 to 145,000 Medicaid enrollees are estimated to be $21.5 to $29.0 million per year (State and Federal) or $10.8 to $14.5 million per year (State only). The on-going costs were developed assuming approximately $200 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in calendar years 2012 and 2013 for the initial administrative expenditures and in calendar year 2014 forward for the on-going expenditures.

c. Pharmacy Rebate Loss for Nebraska

The Affordable Care Act includes increased rebate percentages for covered outpatient drugs provided to Medicaid patients. The minimum rebate percentage is increased from 15.1% to 23.1% for most brand name drugs and from 11% to 13% for generic drugs effective January 1, 2010. However, the Affordable Care Act indicates that the impact will be accrued 100% to the Federal government. Based on instructions regarding the Pharmacy Rebate offset from Department of Health and Human Services to the state Medicaid Directors dated September 28, 2010, we have estimated that no impact will occur to the rebates currently accruing to the state budget.

The following provides additional details regarding the history of the anticipated pharmacy rebate losses and the resulting modification by CMS.

- In a September 28, 2010 letter, CMS modified the instructions originally outlined in an April 22, 2010 letter on how the increased pharmacy rebate will be captured from the total Medicaid rebates.
- April 22, 2010 State Medicaid Director Letter from Department of Health and Human Services RE: Medicaid Prescription Drug Rebates
  - Page 3, Changes in Non-Federal Share of Rebates: "*For brand name drugs subject to the 23.1 percent minimum rebates, we plan to offset an amount equal to the non-Federal*

share of 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP), regardless of whether States received a rebate amount based on the difference between AMP and best price."

- **Initial Estimated Financial Impact August 16, 2010 Letter:** Since the State of Nebraska receives a significant portion of pharmacy rebates on brand name drugs at the difference between AMP and best price, the State of Nebraska would have lost 8 percent of AMP. The overall estimated impact ranged from 20.7% to 22.6% of pharmacy rebates received.

- May 18, 2010 letter from State Medicaid Directors to Ms. Cynthia Mann, Director, Center for Medicaid, CHIP and Survey & Certification
  - Letter outlined the Medicaid Directors' concern regarding the treatment of the recapture of the non-Federal Share of Rebates
  - Page 2, *"The application of this provision to a rebate that is unaffected by the increase in the minimum rebate violates both the letter and the apparent intent thereof. By its terms, this provision applies only to 'amounts received by the State ... that are attributable ... to the increase in the minimum rebate percentage.' "*
- CMS worked with State Medicaid Directors and other organizations, including the American Academy of Actuaries Medicaid Committee, to understand their concerns.
- September 28, 2010 State Medicaid Director Letter RE: Medicaid Prescription Drugs
  - Page 1 – 2, Revised Policy on Federal Offset of Rebates: " ... *However, after further consideration of the offset provisions in section 2501 of the Affordable Care Act, we have decided to reconsider our instructions regarding the calculation of the offset provisions to reflect the lesser of the difference between the increased minimum rebate percentage and the AMP (Average Manufacturers Price) minus BP (Best Price). We plan to offset the amount equal to the increased amount of rebates resulting from the Affordable Care Act.' "*
  - **Updated Financial Impact:** Since the federal offset will only be on the increased rebate value for brand name drugs, there will not be an expected loss of pharmacy rebates to the State of Nebraska.

d. <u>Physician Fee Schedule Increase to Medicare Rates</u>

According to an April 2009 report by the Urban Institute's Health Policy Center, the current Nebraska Medicaid fee schedule reimburses at approximately 82% of the Medicare fee schedule for primary care services. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for a limited set of primary and preventive care services to 100% of the Medicare physician fee schedule. 100% Federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

Full Participation Scenario –

The full participation scenario assumes that DHHS will increase the fee schedule for the required services for both primary care and specialty care providers and will continue the increased fee schedule after calendar year 2014 to assure continued access to physician care. In addition to increasing the expected cost of corresponding existing expenditures by approximately 22%, the analysis reflects an additional $120 per year for the dual eligible population since Medicare only pays 80% of the fee schedule for Part B services.

Under the full participation scenario, the increased cost would be an estimated $27 million (State and Federal) per year for the current Medicaid program and expansion populations. During calendar years 2013 and 2014, the state would have to pay the standard state portion of the increase for specialty providers for the existing Medicaid population. Therefore, the state share in these two calendar years would be approximately $2.8 million (State only) per year. In 2015, the State only cost for the fee schedule expansion would grow to an estimated $9 million (State only).

Mid-Range Participation Scenario –

The mid-range participation scenario assumes that DHHS will only increase the fee schedule for primary care providers, not specialty care providers. The mid-range participation scenario further assumes that the fee schedule increase will only continue through calendar year 2014 and will terminate when the Federal funding level decreases. The annual cost would be approximately $18 million and reflects 100% Federal funding for the calendar year 2013 and 2014 period.

e. Foster Children Coverage to Age 26

It is Milliman's understanding that Nebraska currently provides Medicaid eligibility coverage to Foster Children to age 19. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. Milliman has estimated the annual cost at $5.5 million per year (State and Federal) or approximately $2.3 million per year (State only).

f. Medically Needy Expansion to 138% FPL

The Medically Needy population is currently covered to 43% FPL. The population is limited to non-Dual eligibles under age 65. Effective January 1, 2014, the population will be covered to 138% FPL including the 5% income disregard allowance. Milliman has utilized the DHHS expenditure estimate for the Medically Needy population for fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

g. DSH Reduction

Based upon the aggregate Disproportionate Share Hospital (DSH) payment reductions indicated in the Affordable Care Act, Milliman developed average Federal fiscal year DSH reduction percentages. Milliman adjusted the Federal fiscal year percentages to a State fiscal year basis. The baseline DSH expenditures of $44.0 million provided by DHHS were ultimately reduced to two-thirds of the National reduction percentage. The reduction was reduced to two-thirds of the National percentage to reflect that Nebraska is a low DSH state.

Federal Fiscal Year	DSH Percentage Reduction	
	National Percentage	Nebraska Percentage
2014	4.4%	2.9%
2015	5.3%	3.5%
2016	5.3%	3.5%
2017	15.9%	10.6%
2018	44.1%	29.4%
2019	49.4%	32.9%
2020	35.3%	23.5%

Note: Nebraska percentage reduction was estimated at 2/3 of National percentage reduction since Nebraska is a low DSH state.

h. CHIP Enrollment Shift and FMAP Increase

Under the Affordable Care Act, the CHIP program is required to continue to 2019. However, the legislation provides an additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 93.35%. The enhanced FMAP will decrease expenditures for Nebraska and increase expenditures for the Federal share.

The projection additionally reflects that approximately 30% of current CHIP program enrollees will shift to Medicaid eligibility effective January 1, 2014. The 30% reflects CHIP enrollees <138% FPL.

i. State Disability Shift to Medicaid and Expansion to 138% FPL

Nebraska currently covers the State Disability population to 100% FPL with 100% state funds. Milliman has utilized the DHHS expenditure estimate for the State Disability population for Federal fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

OTHER CHANGES TO CURRENT PROGRAMS

Milliman anticipates potential savings from the following populations even if the programs are not discontinued. However, savings estimates have not been included in the total impact projection for either the full participation scenario or mid-range participation scenario.

Pregnant Women above 138% FPL

The State of Nebraska currently provides eligibility for pregnant women up to 185% FPL. It would be anticipated that the majority of pregnant women between 138% FPL and 185% FPL will receive care through the insurance exchange. We have estimated that approximately 10% of the current expenditures for the pregnant women population will no longer be incurred by the Nebraska Medicaid program. We have estimated the annual savings to be approximately $3.4 million (State and Federal) per year or $1.4 million (State only) per year beginning on January 1, 2014.

Breast and Cervical Cancer Program

The State of Nebraska currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately $5.0 million (State and Federal) or $1.5 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program could be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by DHHS as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 as retrieved from the DHHS website. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Nebraska Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.

Milliman

If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman

ENCLOSURE 1

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Current Programs											
Medicaid											
Total (State and Federal)	$1,745.1	$1,792.5	$1,841.2	$1,891.3	$1,942.7	$1,995.5	$2,049.7	$2,105.4	$2,162.6	$2,221.4	$19,747.6
Federal Funds	$1,029.1	$1,036.8	$1,061.3	$1,090.1	$1,119.8	$1,150.2	$1,181.5	$1,213.6	$1,246.5	$1,280.4	$11,409.3
State Funds	$716.0	$755.7	$780.0	$801.2	$822.9	$845.3	$868.3	$891.9	$916.1	$941.0	$8,338.5
CHIP											
Total (State and Federal)	$63.2	$65.1	$67.0	$69.0	$71.1	$73.3	$75.4	$77.7	$80.0	$82.4	$724.4
Federal Funds	$45.0	$45.9	$47.2	$48.6	$50.0	$51.5	$53.1	$54.7	$56.3	$58.0	$510.3
State Funds	$18.1	$19.2	$19.9	$20.5	$21.1	$21.7	$22.4	$23.0	$23.7	$24.4	$214.1
State Disability											
Total (State and Federal)	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
All Programs											
Total (State and Federal)	$1,816.4	$1,866.0	$1,916.9	$1,969.2	$2,023.0	$2,078.2	$2,134.9	$2,193.2	$2,253.0	$2,314.4	$20,565.3
Federal Funds	$1,074.1	$1,082.7	$1,108.5	$1,138.7	$1,169.8	$1,201.7	$1,234.6	$1,268.2	$1,302.9	$1,338.4	$11,919.6
State Funds	$742.3	$783.3	$808.5	$830.5	$853.2	$876.5	$900.4	$924.9	$950.1	$976.0	$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Health Care Reform											
Adults and Parents - Expansion to 138% FPL											
Total (State and Federal) - Newly Eligible				$142.6	$293.7	$302.5	$311.6	$320.9	$330.5	$340.5	$2,042.2
Total (State and Federal) - Woodwork				$9.2	$18.9	$19.4	$20.0	$20.6	$21.2	$21.9	$131.2
Total (State and Federal) - Insured Switchers				$90.0	$185.3	$190.9	$196.6	$202.5	$208.6	$214.9	$1,288.9
Federal Funds				$237.8	$489.9	$504.6	$507.0	$506.5	$516.3	$520.7	$3,282.9
State Funds				$3.9	$8.0	$8.2	$21.2	$37.5	$44.0	$56.5	$179.3
Children - Impact due to ACA											
Total (State and Federal) - Newly Eligible				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total (State and Federal) - Woodwork				$28.5	$58.6	$60.4	$62.2	$64.0	$66.0	$67.9	$407.6
Total (State and Federal) - Insured Switchers				$18.6	$38.4	$39.6	$40.8	$42.0	$43.2	$44.5	$267.1
Federal Funds				$27.1	$55.9	$57.6	$59.3	$61.1	$62.9	$64.8	$388.9
State Funds				$20.0	$41.1	$42.3	$43.6	$44.9	$46.3	$47.6	$285.8
Administrative Expenses											
Total (State and Federal)		$6.3	$12.5	$17.0	$21.5	$21.5	$21.5	$21.5	$21.5	$21.5	$164.8
Federal Funds		$3.1	$6.3	$8.5	$10.8	$10.8	$10.8	$10.8	$10.8	$10.8	$82.4
State Funds		$3.1	$6.3	$8.5	$10.8	$10.8	$10.8	$10.8	$10.8	$10.8	$82.4
Pharmacy Rebate Loss for Nebraska											
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Physician Fee Schedule Increase to Medicare Rates											
Total (State and Federal)			$7.2	$18.3	$9.4	$0.0	$0.0	$0.0	$0.0	$0.0	$34.9
Federal Funds			$7.2	$18.3	$9.4	$0.0	$0.0	$0.0	$0.0	$0.0	$34.9
State Funds			$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Foster Children Coverage to Age 26											
Total (State and Federal)				$2.8	$5.5	$5.5	$5.5	$5.5	$5.5	$5.5	$35.8
Federal Funds				$1.6	$3.2	$3.2	$3.2	$3.2	$3.2	$3.2	$20.6
State Funds				$1.2	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$15.1
Medically Needy Expansion to 138% FPL											
Total (State and Federal)				$10.6	$21.8	$22.5	$23.2	$23.9	$24.6	$25.3	$151.9
Federal Funds				$10.6	$21.8	$22.5	$22.6	$22.6	$23.0	$23.2	$146.2
State Funds				$0.0	$0.0	$0.0	$0.6	$1.3	$1.6	$2.2	$5.6

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
DSH Reductions											
Total (State and Federal)				($1.0)	($1.5)	($1.6)	($3.9)	($10.9)	($14.1)	($11.4)	($44.3)
Federal Funds				($0.6)	($0.9)	($0.9)	($2.2)	($6.3)	($8.1)	($6.6)	($25.5)
State Funds				($0.4)	($0.6)	($0.7)	($1.7)	($4.6)	($6.0)	($4.8)	($18.8)
CHIP Enrollment Shift and FMAP Increase											
Total (State and Federal)				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds				($1.3)	($2.7)	$6.1	$9.3	$9.5	$9.8	$0.2	$30.9
State Funds				$1.3	$2.7	($6.1)	($9.3)	($9.5)	($9.8)	($0.2)	($30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL											
Total (State and Federal)				$1.6	$3.4	$3.5	$3.6	$3.7	$3.8	$3.9	$23.6
Federal Funds				$6.1	$12.6	$12.9	$13.0	$13.0	$13.2	$13.3	$84.0
State Funds				($4.4)	($9.2)	($9.4)	($9.4)	($9.3)	($9.4)	($9.4)	($60.5)
All Programs - After Expansion											
Total (State and Federal)	$1,816.4	$1,872.2	$1,936.6	$2,307.3	$2,678.0	$2,742.4	$2,815.9	$2,886.9	$2,963.9	$3,049.0	$25,068.7
Federal Funds	$1,074.1	$1,085.8	$1,121.9	$1,446.9	$1,769.7	$1,818.4	$1,857.4	$1,888.6	$1,934.0	$1,968.0	$15,964.8
State Funds	$742.3	$786.4	$814.7	$860.5	$908.3	$923.9	$958.5	$998.3	$1,029.9	$1,081.0	$9,103.9
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$6.3	$19.7	$338.1	$655.0	$664.2	$681.0	$693.8	$710.9	$734.5	$4,503.4
Federal Funds	$0.0	$3.1	$13.5	$308.1	$599.9	$616.7	$622.9	$620.3	$631.1	$629.6	$4,045.2
State Funds	$0.0	$3.1	$6.3	$30.0	$55.1	$47.5	$58.1	$73.4	$79.8	$105.0	$458.2
Pregnant Women (133% - 185%)											
Total (State and Federal)				($1.6)	($3.3)	($3.4)	($3.5)	($3.6)	($3.7)	($3.8)	($22.8)
Federal Funds				($0.9)	($1.9)	($2.0)	($2.0)	($2.1)	($2.1)	($2.2)	($13.2)
State Funds				($0.7)	($1.4)	($1.4)	($1.5)	($1.5)	($1.6)	($1.6)	($9.7)
Breast & Cervical Cancer											
Total (State and Federal)				($2.4)	($5.0)	($5.2)	($5.3)	($5.5)	($5.6)	($5.8)	($34.8)
Federal Funds				($1.7)	($3.5)	($3.6)	($3.7)	($3.8)	($3.9)	($4.0)	($24.4)
State Funds				($0.7)	($1.5)	($1.5)	($1.6)	($1.6)	($1.7)	($1.7)	($10.3)

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ENCLOSURE 2

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Maximum Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Current Programs											
Medicaid											
Total (State and Federal)	$1,745.1	$1,792.5	$1,841.2	$1,891.3	$1,942.7	$1,995.5	$2,049.7	$2,105.4	$2,162.6	$2,221.4	$19,747.[illegible]
Federal Funds	$1,029.1	$1,036.8	$1,061.3	$1,090.1	$1,119.8	$1,150.2	$1,181.5	$1,213.6	$1,246.5	$1,280.4	$11,408.[illegible]
State Funds	$716.0	$755.7	$780.0	$801.2	$822.9	$845.3	$868.3	$891.9	$916.1	$941.0	$8,338.[illegible]
CHIP											
Total (State and Federal)	$63.2	$65.1	$67.0	$69.0	$71.1	$73.3	$75.4	$77.7	$80.0	$82.4	$724.[illegible]
Federal Funds	$45.0	$45.9	$47.2	$48.6	$50.0	$51.5	$53.1	$54.7	$56.3	$58.0	$510.[illegible]
State Funds	$18.1	$19.2	$19.9	$20.5	$21.1	$21.7	$22.4	$23.0	$23.7	$24.4	$214.[illegible]
State Disability											
Total (State and Federal)	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.[illegible]
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.[illegible]
State Funds	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
All Programs											
Total (State and Federal)	$1,816.4	$1,866.0	$1,916.9	$1,969.2	$2,023.0	$2,078.2	$2,134.9	$2,193.2	$2,253.0	$2,314.4	$20,565.[illegible]
Federal Funds	$1,074.1	$1,082.7	$1,108.5	$1,138.7	$1,169.8	$1,201.7	$1,234.6	$1,268.2	$1,302.9	$1,338.4	$11,919.[illegible]
State Funds	$742.3	$783.3	$808.5	$830.5	$853.2	$876.5	$900.4	$924.9	$950.1	$976.0	$8,645.[illegible]

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Maximum Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Health Care Reform											
Adults and Parents - Expansion to 138% FPL											
Total (State and Federal) - Newly Eligible				$174.6	$359.6	$370.4	$381.5	$393.0	$404.8	$416.9	$2,500.8
Total (State and Federal) - Woodwork				$13.1	$26.9	$27.8	$28.6	$29.4	$30.3	$31.2	$187.1
Total (State and Federal) - Insured Switchers				$147.2	$303.3	$312.4	$321.8	$331.4	$341.4	$351.6	$2,109.1
Federal Funds				$329.3	$678.5	$698.8	$702.2	$701.5	$715.1	$721.2	$4,546.6
State Funds				$5.5	$11.4	$11.8	$29.7	$52.3	$61.3	$78.6	$250.4
Children - Impact due to ACA											
Total (State and Federal) - Newly Eligible				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total (State and Federal) - Woodwork				$35.6	$73.3	$75.5	$77.7	$80.1	$82.5	$84.9	$509.5
Total (State and Federal) - Insured Switchers				$24.9	$51.2	$52.8	$54.3	$56.0	$57.6	$59.4	$356.2
Federal Funds				$34.8	$71.7	$73.9	$76.1	$78.4	$80.8	$83.2	$498.9
State Funds				$25.6	$52.7	$54.3	$55.9	$57.6	$59.3	$61.1	$366.4
Administrative Expenses											
Total (State and Federal)		$6.3	$12.5	$20.8	$29.0	$29.0	$29.0	$29.0	$29.0	$29.0	$213.5
Federal Funds		$3.1	$6.3	$10.4	$14.5	$14.5	$14.5	$14.5	$14.5	$14.5	$106.8
State Funds		$3.1	$6.3	$10.4	$14.5	$14.5	$14.5	$14.5	$14.5	$14.5	$106.8
Pharmacy Rebate Loss for Nebraska											
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Physician Fee Schedule Increase to Medicare Rates											
Total (State and Federal)			$10.1	$27.3	$28.1	$28.9	$29.7	$30.5	$31.3	$32.2	$218.1
Federal Funds			$8.9	$24.5	$22.7	$20.3	$20.6	$20.9	$21.4	$21.8	$161.1
State Funds			$1.2	$2.8	$5.4	$8.6	$9.0	$9.5	$9.9	$10.4	$56.8
Foster Children Coverage to Age 26											
Total (State and Federal)				$2.8	$5.5	$5.5	$5.5	$5.5	$5.5	$5.5	$35.8
Federal Funds				$1.6	$3.2	$3.2	$3.2	$3.2	$3.2	$3.2	$20.8
State Funds				$1.2	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$15.0
Medically Needy Expansion to 138% FPL											
Total (State and Federal)				$10.6	$21.8	$22.5	$23.2	$23.9	$24.6	$25.3	$151.9
Federal Funds				$10.6	$21.8	$22.5	$22.6	$22.6	$23.0	$23.2	$146.4
State Funds				$0.0	$0.0	$0.0	$0.6	$1.3	$1.6	$2.2	$5.5

(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
DSH Reductions											
Total (State and Federal)				($1.0)	($1.5)	($1.6)	($3.9)	($10.9)	($14.1)	($11.4)	($44.5)
Federal Funds				($0.6)	($0.9)	($0.9)	($2.2)	($6.3)	($8.1)	($6.6)	($25.6)
State Funds				($0.4)	($0.6)	($0.7)	($1.7)	($4.6)	($6.0)	($4.8)	($18.8)
CHIP Enrollment Shift and FMAP Increase											
Total (State and Federal)				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds				($1.3)	($2.7)	$6.1	$9.3	$9.5	$9.8	$0.2	$30.9
State Funds				$1.3	$2.7	($6.1)	($9.3)	($9.5)	($9.8)	($0.2)	($30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL											
Total (State and Federal)				$1.6	$3.4	$3.5	$3.6	$3.7	$3.8	$3.9	$23.5
Federal Funds				$6.1	$12.6	$12.9	$13.0	$13.0	$13.2	$13.3	$84.1
State Funds				($4.4)	($9.2)	($9.4)	($9.4)	($9.3)	($9.4)	($9.4)	($60.6)
All Programs - After Expansion											
Total (State and Federal)	$1,816.4	$1,872.2	$1,939.5	$2,426.7	$2,923.6	$3,004.8	$3,085.9	$3,164.7	$3,249.7	$3,343.0	$26,826.5
Federal Funds	$1,074.1	$1,085.8	$1,123.6	$1,554.2	$1,991.2	$2,053.0	$2,093.8	$2,125.6	$2,175.7	$2,212.4	$17,489.3
State Funds	$742.3	$786.4	$815.9	$872.5	$932.4	$951.8	$992.1	$1,039.1	$1,074.0	$1,130.7	$9,337.2
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$6.3	$22.6	$457.4	$900.7	$926.6	$951.0	$971.5	$996.7	$1,028.6	$6,261.4
Federal Funds	$0.0	$3.1	$15.1	$415.5	$821.4	$851.3	$859.2	$857.3	$872.8	$874.0	$5,569.7
State Funds	$0.0	$3.1	$7.5	$42.0	$79.2	$75.3	$91.7	$114.2	$123.8	$154.6	$691.5
Pregnant Women (133% - 185%)											
Total (State and Federal)				($1.6)	($3.3)	($3.4)	($3.5)	($3.6)	($3.7)	($3.8)	($22.8)
Federal Funds				($0.9)	($1.9)	($2.0)	($2.0)	($2.1)	($2.1)	($2.2)	($13.2)
State Funds				($0.7)	($1.4)	($1.4)	($1.5)	($1.5)	($1.6)	($1.6)	($9.7)
Breast & Cervical Cancer											
Total (State and Federal)				($2.4)	($5.0)	($5.2)	($5.3)	($5.5)	($5.6)	($5.8)	($34.8)
Federal Funds				($1.7)	($3.5)	($3.6)	($3.7)	($3.8)	($3.9)	($4.0)	($24.1)
State Funds				($0.7)	($1.5)	($1.5)	($1.6)	($1.6)	($1.7)	($1.7)	($10.7)

Exhibit 2

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

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF ROBERT D. CHURCH, JR.

Pursuant to 28 U.S.C. § 1746, I, Robert D. Church, Jr, declare the following:

1. My name is Robert D. Church, Jr. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Alabama Medicaid Agency as the Commissioner of the Agency and as the Chief Financial Officer.

2. I have served as Chief Financial Officer since approximately November, 2009 and as Commissioner since November, 2010.

3. As Commissioner, I am the highest ranking official in the Alabama Medicaid Agency and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Alabama is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Presently, Alabama Medicaid Agency has projected that the initial administrative cost to the state will total over $76,000,000 by the conclusion of state Fiscal Year 2015 as a result of the passage of PPACA. This amount increases going forward, and by 2018 the projected administrative costs to Alabama are estimated to be in excess of $35,000,000 annually from the state's general fund. There are, currently, no projected savings as a result of PPACA.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Montgomery, Alabama.

Robert D. Church, Jr.
Commissioner
Alabama Medicaid Agency

SWORN TO and subscribed before me this 19 day of November, 2010.

Angela Williams
Notary Public

My Commission Expires: May 16, 2012

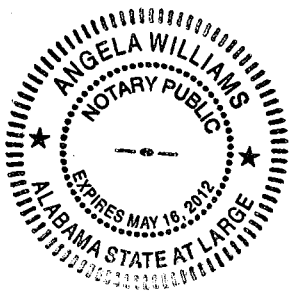

Exhibit 3

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

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF ROBERT M. DAMLER

Pursuant to 28 U.S.C. § 1746, I, Robert M. Damler, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Indiana is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

2. I am a Principal and Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

3. Indiana Code § 12-8-1-7 gives the secretary of the Indiana Family and Social Services Agency (FSSA) the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act (H.R. 3590) as it relates to the provisions impacting the State's Medicaid program and budget.

4. I provided a declaration earlier in this matter certifying the authenticity of a report I provided to FSSA concerning PPACA's impact on the Medicaid program. That report is attached as Exhibit A to the declaration of Pat Casanova, the head of the Indiana Office of Medicaid Policy and Planning, which declaration was supplied as Exhibit 10 in support of the Plaintiffs' Motion for Summary Judgment. I am the principal author of that report.

5. In my report dated October 18, 2010 to FSSA, I projected that PPACA is likely to increase the Indiana expenditures on the Medicaid program to be between $2.6 billion and $3.1 billion through state fiscal year 2020. The FSSA report did not reflect savings to other areas of the Indiana budget.

6. I have reviewed Part II.C.1 of the memorandum filed on November 4, 2010, by the United States Department of Health and Human Services in support of its motion for summary judgment in this matter and Exhibit 33 thereto.

7. On pp. 39-41 of DHHS's summary judgment memorandum, DHHS claims that the PPACA will save the State of Indiana millions of dollars per year. This claim is based on Exhibit 33 to DHHS's motion for summary judgment, a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009, and titled *The Impact of Health Insurance Reform on State and Local Governments* (CEA Report).

8. There are several assumptions used in the DHHS's calculations that are not consistent with the actual experiences of the State of Indiana. Under PPACA, the State of Indiana would not be expected to save $338 million per year compared with current State indigent care programs (as described in the CEA report), but instead may incur an additional $50 million per year or more compared with current outlays for indigent care programs.

9. Page 34 of the CEA Report at Exhibit 33 presents an estimated annual increased Medicaid cost for Indiana of $62 million based on a Federal Medical Assistance Percentage (FMAP) of 90%. This calculation is based on adding to the State's Medicaid rolls 189,000 currently uninsured adults and parents at a cost of $2,974 per person per year, and 31,600 currently uninsured children at a cost of $1,898 per child per year. This equates to a total combined State and Federal outlay of $563 million for adults and parents and $60 million for children each year. My analysis shows that the CEA's estimated cost for parents and adults is too low at $2,974 per year. My estimate, based on Indiana-specific data of the actual age and gender of the uninsured population, with adjusted morbidity, would be approximately $3,600 per year, which is 21% greater than the CEA's $2,974 value. As a further comparison, the Kaiser Commission on Medicaid and the Uninsured report titled, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL" utilized an average cost for Indiana for the period of 2014 to 2019 estimated to be $4,300 to $5,000. These values are estimates since full details were not published in the report.

10. Furthermore, the CEA's estimated annual increased Medicaid cost for Indiana in Exhibit 33 did not account for any parents or adults that are currently *insured* but who are likely to switch to the Medicaid program once that becomes available. My previously published estimate anticipates an additional 107,000 currently insured adults and parents will enroll in the Indiana Medicaid program, which is more than a 50% increase to the CEA's estimate of parents and adults likely to

join the Indiana Medicaid program. In addition to my previously published estimates, the Kaiser Commission report previously referenced 216,000 to 338,000 uninsured adults and parents will be enrolled in Medicaid by 2019. In addition to the previously uninsured enrollment, the Kaiser Commission report anticipates total adult and parent Medicaid enrollment to expand by 298,000 to 427,000 including both the uninsured and insured populations.

11. The CEA's estimates were based on earlier versions of health care reform legislation that would have expanded Medicaid eligibility to 133% of the Federal Poverty Level (FPL), which is not consistent with the final PPACA legislation. While PPACA specifies an income threshold of 133 percent of FPL for the Medicaid expansion, it also requires states to apply an "income disregard" of 5% of FPL in meeting the income test. Therefore, the effective income threshold is actually 138% of FPL. *See* Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services memorandum, April 22, 2010, at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (November 4, 2010).

12. Adjusting the CEA estimate for the higher cost per recipient noted in paragraph 9 above (a 21% increase), the likelihood that currently insured adults and parents will switch to Medicaid under the new PPACA standards noted in paragraph 10 (a 50% increase), and the expanded Medicaid population at the higher FPL noted in paragraph 11 (a 5% increase), the Adult/Parent Population would cost an estimated $1,072 million (State and Federal contribution combined) or $107 million State contribution at 90% FMAP. The $107 million State contribution would compare to the $56.3 million illustrated by the CEA.

13. The CEA calculations need further modifications. First, the illustration applied the 90% FMAP to the children population, which would not be appropriate. Rather, this population will receive the standard FMAP, which is approximately 66% for Indiana in FFY 2011. This 34% State contribution for children means that the State portion of the Medicaid increase will be $20 million, not $6 million as the CEA estimates on page 37, Table 2 of Exhibit 33. With this correction, the total estimate of the State's increased Medicaid exposure would be $127 million, as compared to the $62 million the CEA has estimated in Exhibit 33.

14. Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive provisions of major health and welfare programs authorized under the Act, thus allowing states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules. Indiana received such a waiver for the Healthy Indiana Plan. Because of the waiver, in addition to adjusting the FMAP on the children population, the State of Indiana may incur lower FMAP on a portion of the expansion population. Indiana may lose the enhanced FMAP of 90% on the first 34,000 lives, which corresponds to the number of childless adults that are allowed under Indiana's Section 1115 waiver for the Healthy Indiana

Plan. Although a final decision has not been provided by CMS, the loss in the enhanced FMAP would have a significant financial impact on the Medicaid Assistance budget. The 24% reduction in FMAP yields an additional $75 million cost for Indiana per year of Federal funds. This would be added to the $127 million value noted in paragraph 13.

15. The CEA's illustrations for Indiana in Exhibit 33 also does not include an estimate for administrative costs for enrollment, claims processing, and other administrative functions of serving an additional 300,000 lives. The administrative costs are generally matched at 50% Federal share/50% State share. We estimate that state share of these administrative costs would be $28 million per year.

16. After accounting for the modifications listed in paragraphs 12-15 above, Indiana's share of increased Medicaid costs under PPACA may be estimated at nearly $230 million per year, as compared to CEA illustrated amount of $62 million per year.

17. Another aspect that is unique to Indiana and other state Medicaid agencies relates to the disabled population eligibility requirements. The State of Indiana operates as a Section 209(b) state, which allows the State of Indiana to have different disability eligibility criteria. Since Indiana is a Section 209(b) state, it also provides eligibility under a spend-down provision requiring recipients to spend down their excess monthly income toward medical expenses before they are eligible for Medicaid. Due to this eligibility determination rule, there are approximately 22,000 individuals that are SSI disabled that do not qualify for the Medicaid disability eligibility in Indiana. Although CMS has not yet provided a final determination, Indiana may not receive the enhanced FMAP for these additional individuals under the new eligibility provisions of ACA. To the extent that the standard FMAP applies to the disabled population, the additional cost to the State of Indiana would be $90 million per year. It does not appear that the CEA estimate included an adjustment for this population. By combining the annual cost savings noted in this paragraph of $90 million with the total of $230 million in paragraph 16, the cost could be re-stated as $320 million.

18. Exhibit 33 also over-estimates cost savings that Indiana is likely to realize as a result of the Medicaid Expansion. For example, the CEA has illustrated a value of $154 million for the cost of the Healthy Indiana Plan. These funds may be diverted beginning in January 1, 2014, to assist in covering the cost of the Medicaid expansion. However, the State's actual commitment to the Healthy Indiana Plan is limited by the amount of the State's Cigarette Tax revenues that the General Assembly has allocated to HIP. The current annual revenue has been approximately $125 million per year, rather than the $154 million illustrated by the CEA.

19. Exhibit 33 also illustrates a savings of $126 million per year through the Hospital Uncompensated Care for the Indigent (HCIP) program. However, CEA

inadvertently illustrated the biennial budget amount for HCIP rather than the single year value. The actual annual savings for canceling HCIP in light of expanded Medicaid under PPACA would be $63 million per year.

20. The CEA report also *under*estimates cost savings the State may realize from cancelling its high-risk pool ICHIA program. The CEA estimates that the State currently spends about $15 million annually on that program, but annual outlays are closer to approximately $40 million per year.

21. By combining the annual savings figures noted in paragraphs 18, 19 and 20 ($125M + $63M + 40M), the savings would be re-stated at approximately $228 million per year from these three sources rather than the $296 million estimated by CEA on page 38, Table 3 of Exhibit 33.

22. The differences between our estimates for Indiana and CEA's estimates are illustrated in the following table:

	Milliman/Indiana	CEA, Exhibit 33 at Table 3
Medicaid Expansion	$(320)M	$(62)M
Healthy Indiana Plan	$125M	$155M
ICHIA	$40M	$15M
Tax Credit	$12M	$12M
HCIP	$63M	$126M
Hidden Tax	$30M	$30M
Net Impact	$(50)M	$275M

Note: Values have been rounded to millions.

23. There are further qualifications of these amounts. HCIP, for example, is not a stand-alone state program, but is instead part of Indiana's Medicaid Plan. Accordingly, Indiana will actually continue to incur the full cost of HCIP even as it assumes greater costs for expanded Medicaid coverage under PPACA. So, reducing that savings line item to zero, Indiana's Medicaid exposure will actually be near $113 million.

24. It is also important to observe that, while Medicaid expansion costs are in today's dollars which will inflate over time, the State's revenue stream currently dedicated for funding HIP and HCIP, the Indiana Cigarette Tax, will not. In fact, since Indiana's Cigarette Tax increased to 44 cents per pack and an additional federal cigarette tax has been implemented, Cigarette Tax revenue has decreased as more and more smokers quit smoking. That revenue stream is, thus, highly unlikely to keep pace with inflation, meaning that Indiana will have to find other revenue sources to pay its share of the expanded Medicaid program that is mandated by PPACA, not by its own program decisions.

25. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 18th day of November, 2010.

Robert M. Damler, FSA, MAAA, Principal and Consulting Actuary, Milliman, Inc., 111 Monument Circle, Suite 601, Indianapolis, Indiana 46204

Exhibit 4

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

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

FURTHER DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.

2. I have served as Interim Secretary since September 2010.

3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. The facts and statements in this further declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I previously provided a declaration in this matter describing the projected impacts of the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) on the Florida Medicaid program. As I stated in that declaration, AHCA projects that PPACA will cost the Florida Medicaid program $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in general revenue.

6. I have since reviewed the Defendants' claim that PPACA will save the State of Florida $377 million per year, which appears to be based on a report by the

Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. The CEA report, however, does not appear to address the impact of the final version of PPACA on the state government of Florida. In fact, at the time the CEA Report was issued in September 2009, PPACA was not yet in its final form. Thus, it appears that the CEA Report only attempted to address possible impacts of PPACA, while guessing at what the national health care reform effort would look like when it was completed.

8. The Defendants appear to draw their $377 million savings figure from a column of a chart on page 26 of the Report (the exact figure in the column is $377.3 million). Two assumptions made with respect to this $377 million amount did not come to pass, however, in PPACA's final version. First, the $377 million figure assumes 100% federal financing of Medicaid expansion. CEA Report p. 26. PPACA itself only ultimately provides for 90% federal financing. The state governments, including Florida's, will supply the other 10%. The $377 million figure in the Report thus underestimates the costs to the state government of Florida from Medicaid expansion. Second, the CEA Report appears to assume that, if the national health care reform effort were to be successful, all uncompensated care would disappear. This also did not come to pass in PPACA's final form.

9. Using the CEA Report to forecast savings to the State of Florida also presents other issues. For example, the CEA Report analyzes possible savings to be realized by state *and local* governments taken together. All or virtually all of the $377 million in projected savings described in the report would accrue to local governmental entities such as Miami-Dade County, Hillsborough County, and Duval County. As AHCA Interim Secretary, I have no knowledge regarding any alleged or projected costs or savings to these local governments, and thus cannot testify as to whether the localities described will realize any net savings from PPACA.

10. The CEA Report, however, appears to project that all uncompensated care in Florida would disappear (which did not actually occur in PPACA's final form), and that local governments will save as a result. CEA Report at p. 24, 26. Uncompensated care is not likely to disappear as a result of PPACA. To the extent uncompensated care diminishes as a result of PPACA, local government savings from its disappearance generally will not result in any savings to the state government's budget. In fact, a reduction in uncompensated care may be at least partially the result of previously uninsured persons enrolling in Medicaid. In other words, any savings realized by local governments from a reduction in uncompensated care might actually increase costs for Florida Medicaid.

11. Finally, the CEA Report forecasts that additional savings ($117 million) "may come" from the Children's Health Insurance Program. CEA Report at pp. 24-25. My prior declaration included AHCA projections that incorporated the State of Florida's potential for savings related to CHIP (*see* ¶ 20), such that this figure does not discount the annual estimated cost to the State of Florida to which I previously attested (*see* ¶ 5, above).

12. As a result of the factors described above, AHCA stands by the projections contained in my previous declaration, and will not alter its projections based on the CEA Report.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 18, 2010, in Tallahassee, Florida.

Elizabeth Dudek
Interim Secretary
Agency for Health Care Administration

Exhibit 5

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

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

DECLARATION OF J. ERIC PRIDGEON

Pursuant to 28 U.S.C. § 1746, I, J. Eric Pridgeon, declare the following:

1. My name is J. Eric Pridgeon. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida House of Representatives as the Budget Chief for Health Care Appropriations.

2. I have served as Budget Chief since 2008. I have 15 years of experience working on Medicaid budget and policy matters at the state level.

3. As the Budget Chief, I write the annual budget for the Florida Medicaid program. In addition, I serve as a principal for the Social Services Estimating Conference which projects enrollment and costs for the Medicaid program, and monitor Medicaid expenditures and analyze budget amendments throughout the fiscal year. Based on my employment, I am familiar with the Patient Protection and Affordable Care Act (PPACA) and the effects (actual and projected) of the PPACA on Florida's Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Florida is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Earlier declarations were provided in this matter by Elizabeth Dudek, Interim Secretary, State of Florida, Agency for Health Care Administration, and by Joanne Leznoff, Staff Director of the Appropriations Committee, State of Florida, House of Representatives. Those declarations attested to the impact of the

Medicaid program provided in the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA).

6. I have since reviewed the Defendants' Memorandum in Support of their Motion for Summary Judgment and their claim that the PPACA will save Florida's state and local governments $377 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. Defendants cite several local government programs to arrive at this savings estimate.

8. To the extent that local governments seek to reduce some of the cited expenditures, they could only do so at a cost to the State of Florida.

9. Hillsborough County and Miami-Dade County both participate in funding the Medicaid program along with 20 other local governments that collectively provide over $584 million in intergovernmental transfers – funds that are used for the state Medicaid program.

10. The Hillsborough County and Miami-Dade County funding cited by the CEA Report are incorporated into the Medicaid program because these same sources (in whole or in part) are transferred to the State of Florida and used to draw federal Medicaid matching funds before being paid to hospitals within those counties in support of the local programs and providers described in the CEA Report.

11. Miami-Dade County and Hillsborough County contributed approximately $269 million of the intergovernmental transfers from local governments incorporated into the FY 2010-11 Medicaid budget.

12. Regardless of whether the specific local programs cited in the CEA Report remain intact following implementation of PPACA, the State of Florida is dependent upon the contribution of local tax dollars to underwrite core costs of the Medicaid program including funding of specific or "exempt" payment rates to select hospitals (e.g. teaching hospitals, children's hospitals, and rural hospitals) and funding for specialty services such as trauma care and pediatric services.

13. The specific payment rates are known as "exempt" rates because these rates are not bound by statutory ceilings established by the Legislature as a way to manage Medicaid hospital expenditures within appropriations.

14. Loss of the local funding, should such a loss result from implementation of PPACA, would cost the State of Florida the equivalent of any "savings" to local government because the availability of essential services funded by intergovernmental transfers would be at risk if payments were reduced to non-exempt rates and funding for specialty services was eliminated.

15. The CEA Report upon which Defendants rely also assumes the elimination of uncompensated care in Florida ($102 million "Hidden Tax" estimate (CEA Report at 24)), which is contrary to the PPACA's own estimate of providing less than universal coverage (PPACA § 1501(a)). The CEA Report also bases this estimate on costs borne by both state *and local* governments, such that it is not accurate to attribute the full $102 million savings estimate to the State of Florida alone. The CEA Report does not set forth all the assumptions used to arrive at this number.

16. Defendants cite John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [PPACA] on the States?* (June 2010) at 2 for the proposition that state and local governments would save approximately $70-80 billion over the 2014-19 period by shifting state-funded coverage into federally-matched Medicaid. The Holahan and Dorn report does not set forth all the assumptions used to arrive at this number. The Congressional Research Service (CRS) reports that varying impacts are projected for different states, with one state anticipating some savings, but no offsets are noted. (Six states anticipate more than $38 billion in increased costs.) Memorandum, *Variations in Analyses of PPACA's Fiscal Impact on States* (September 8, 2010).

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 22, 2010, in Tallahassee, Florida.

J. Eric Pridgeon
Budget Chief, Health Care Appropriations Committee
Florida House of Representatives

Congressional Research Service

MEMORANDUM September 8, 2010

To: General Distribution Memorandum

From: Evelyne Baumrucker, Analyst in Health Care Financing, 7-8913
Bernadette Fernandez, Specialist in Health Care Financing, 7-0322

Subject: **Variation in Analyses of PPACA's Fiscal Impact on States**

This congressional distribution memorandum, prepared to enable distribution to more than one congressional client, summarizes existing analyses of the impact of the new federal health reform law, the Patient Protection and Affordable Care Act (PPACA), on state costs. The memorandum identifies select coverage provisions (specifically Medicaid and private health insurance) that relate directly to state costs, and discusses the challenges to producing state-level estimates. Such challenges include the pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state decisions regarding such implementation; data issues; and other factors outside of the health reform law and its implementation.

Introduction

The President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148) on March 23, 2010, which has since been amended by several laws. PPACA, as amended, makes many significant changes to the private and public markets for health insurance, and modifies aspects of the publicly financed health care delivery system. Among the major provisions, the law establishes an individual mandate for most U.S. residents to obtain health insurance, reforms the private health insurance market, establishes American Health Benefits Exchanges for individuals and small businesses to shop for private coverage; expands Medicaid eligibility; creates programs to improve quality of care; addresses healthcare workforce issues; and makes a number of other Medicaid and Medicare program and federal tax code changes. It also offers mechanisms to increase care coordination, encourage more use of preventive health, and improve the quality of care.

Enormous variation already exists across states in terms of health insurance coverage rates, generosity of coverage under state-administered public programs, generosity of state-financed programs to purchase private coverage, health insurance regulation, and other factors that affect state responsibilities and budgets. PPACA modifies many of those programs and insurance standards. Given the complexity of the health care system prior to PPACA, and the many changes generated by the new law, the impact on states will vary and will be difficult to estimate, even with the best modeling.

Another challenge in producing cost estimates of the impact of PPACA will be to disentangle such costs from the overall trend of increasing health care costs that would have occurred in its absence. In recent years, "the cost of health coverage continued its steady climb, while employer-sponsored coverage fell.

While the full impact of the recession on employer-sponsored coverage (and overall rates of uninsurance) remains to be seen, state revenues declined just when demand for services rose."[1] Given such trends, it would be useful to identify the costs that states would face in the absence of comprehensive reform in order to understand the cost differences associated with PPACA. One study attempted to do such an analysis, modeling best, intermediate, and worst case scenarios over a 10-year span. Even in the best case, the researchers estimated that without reform, about ¼ of states would see Medicaid/CHIP cost growth of more than 65 percent over the 10 year period, and that employer spending on health insurance premiums would increase in all states.[2]

In response to congressional interest resulting from PPACA, we developed this memorandum to address issues related to potential costs to states. The focus of this memorandum is on health insurance coverage provisions of PPACA, specifically major provisions that permanently change existing state programs and requirements, such as Medicaid and private health insurance regulations. For ease of analysis we address Medicaid and private health insurance separately, but implementation of PPACA necessitates interaction between private and public provisions. Likewise, any thorough estimate of costs should consider these provisions in the context of the current health insurance system and its multiple moving parts.

Given that CRS does not produce cost estimates, we have no plan to produce fiscal impact statements for any state. However, individual states, CBO, and other organizations have generated national and, in some cases, state-level cost estimates based on PPACA coverage provisions (or some portion thereof).[3] In general the cost estimates that we identified focused on the Medicaid program, presumably because it generally represents a substantial portion of state health care budgets, and is an existing program for which current and historical data exists. To the extent that these state studies discussed private health insurance provisions, the discussion focused on mainly descriptive analyses of state responsibilities under PPACA.

It is not our intent to evaluate the validity of the assumptions or the analytic rigor of the methodological approaches used to generate these estimates. Instead, we present the general findings as well as selected assumptions and limitations as reported in the studies that will help the reader put the results into context and better understand the complexity involved in generating estimates of the law's impacts.

In some cases it is unclear whether the cost analyses only consider changes to existing programs and regulations, and do not account for new funding opportunities which may help states with implementation costs.[4] In addition, analyses might not account for the interaction among provisions that could significantly affect costs. According to the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, "the actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are uncertain. The legislation would result in numerous changes in the

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[1] "State of the States: The State We're In," Robert Wood Johnson Foundation, Jan. 2010, p. 5, available online at http://www.statecoverage.org/files/State%20of%20the%20States%202010.pdf.

[2] J. Holohan, L. Doan, and I. Headen, "The Cost of Failure to Enact Health Reform: Implications for States," Urban Institute, Oct. 1, 2009, available online at http://www.urban.org/publications/411965.html.

[3] We use the phrase "coverage provisions" to refer to the provisions in PPACA that would affect existing public programs (e.g., Medicaid) or establish new coverage options (e.g., exchanges). Generally, these provisions are in Titles I and II of PPACA.

[4] Examples of such state funding opportunities include grants for planning and implementing exchanges, and grants to establish (or expand) health insurance consumer assistance programs. See "Patient Protection and Affordable Care Act (P.L. 111-148): Potential Funding Opportunities for States," National Association of Insurance Commissioners, April 7, 2010, available online at http://www.naic.org/documents/index_health_reform_general_nga_funding_chart.pdf.

way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation."[5]

What follows is a summary of selected state-level cost analyses (available as of August 31, 2010) that were prepared by a variety of organizations to assess the impact of PPACA on the state's budget. These organizations include: (1) state agencies that administer Medicaid and/or the State Children's Health Insurance Program (CHIP); (2) state legislative support agencies, (3) independent consultants retained by the state to provide a financial review of the impacts of PPACA on the state's budget, and (4) organizations (e.g., independent Boards established by the state legislature) whose role is to provide input into policy and planning for the state. **Table 1** (see Appendix) summarizes state-specific analyses of PPACA's impact on enrollment in public programs, the uninsured, and costs.

State-specific cost estimates vary. This variation is a function of the fact that each state analysis employs different methods and assumptions, and considers different sets of variables in producing coverage and cost estimates. For example, the Texas study (April 2010) provides cost estimates associated with the Medicaid and CHIP provisions for the time period between state fiscal year (SFY) 2014 through SFY2023. In addition to the fact that cost estimate is reported in terms of the state's fiscal year (as compared to federal fiscal year), it represents a timeframe that includes 4 additional years beyond the budget horizon that CBO, for example, takes into account in its cost estimate (through FY2019).[6] In another example, the Kansas study (May 2010) reports that its cost estimates are expressed in constant dollars using 2011 as a base, but other states do not specify how their estimate is expressed. Finally, because many non-citizens are not eligible for either Medicaid or CHIP, and unlawfully present individuals are ineligible for subsidies to purchase coverage through state exchanges, imputations to account for immigration status must also be applied. In the Kaiser report (May 2010) the methodology section describes how the researchers attempted to account for legal immigrant status in their model. However, it is not clear whether or to what extent other state specific cost estimates have attempted to capture this component. Because these state-specific analyses vary considerably in terms of what they have tried to take into consideration, it is not useful or advisable to compare their results against one another. Nonetheless, the state-specific analyses do provide value in understanding the law's provisions that states are currently focusing on the impacts on their state budgets.

Table 2 (see Appendix) summarizes studies whose state cost estimates provided a break out of the Medicaid/CHIP effects of PPACA's coverage provisions (e.g., increases in enrollment due to the individual mandate, the mandatory expansions of the Medicaid program, and the requirement for Medicaid and CHIP to coordinate with exchange coverage). It is important to note that while these studies have attempted to answer the same basic question, variation in the findings exists. To further underscore this point, the Kaiser study (May 2010)[7] shows that results fluctuate considerably when different

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[5] Foster, R. S., "Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended," Centers for Medicare and Medicaid Services, Baltimore, MD, April 22, 2010, available at http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

[6] CBO's estimate covers the FY2010-FY2019 time frame to be consistent with the budget horizon used under S. Con. Res. 13, the Concurrent Resolution on the Budget for Fiscal Year 2010. Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010.

[7] John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010, available at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

participation rates are assumed. In an attempt to capture a range of potential impacts, Kaiser modeled the PPACA's impacts on Medicaid and CHIP enrollment and spending based on two levels of program participation (i.e., 57% participation rate as compared to a 75% participation rate). **Table 2** shows the variation that results when these different participation rates are applied.

Major PPACA Provisions with Potential State Cost Implications

For ease of analysis we address Medicaid and private health insurance provisions separately here, but implementation of PPACA necessitates interaction between private and public provisions. Likewise, cost estimates should account for such interactions within the context of the broader health insurance system.

Medicaid and CHIP

PPACA makes significant changes to the Medicaid[8] and CHIP[9] programs.[10] Although not an exhaustive list, some of the major changes that could potentially increase state costs include:

- State requirement to expand Medicaid to nonelderly, nonpregnant adults with income up to 133% of the federal poverty level (FPL).[11] From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of "newly eligible"[12] individuals, with the percentage dropping to 90% by 2020. States cover the percentage not paid by the federal government.
- State requirement to maintain existing Medicaid and CHIP eligibility levels (MOE) for adults until exchanges are fully operational (presumably CY 2014) and for children through 2019 as a condition of receiving federal matching funds for Medicaid expenditures.
- State requirement to improve outreach, streamline enrollment, and coordinate with CHIP and the proposed exchanges that may result in increases in applications and enrollment

[8] Medicaid is a federal and state matching program that finances the delivery of health care services for certain populations with limited incomes. Each state that chooses to participate designs and administers its own version of Medicaid under broad federal rules. Individuals who meet state eligibility requirements are entitled to services covered under the state plan. To qualify, an individual must meet both categorical (i.e., must be a member of a covered group such as children, pregnant women, families with dependent children, the elderly, or the disabled), and financial eligibility requirements.

[9] CHIP, also a federal and state matching program, provides health care coverage to certain low-income, uninsured children in families with income above Medicaid income standards. States may also extend CHIP coverage to pregnant women when certain conditions are met. In designing their CHIP programs, states may choose to expand Medicaid, create a stand-alone program, or use a combined approach.

[10] For more information on PPACA's changes to Medicaid and CHIP see CRS report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP): Summary and Timeline,* Coordinated by Julie Stone, August 19, 2010.

[11] For individuals whose income will be determined using new income counting rules, the law also specifies that an income disregard in the amount of 5% FPL be deducted from an individual's income when determining Medicaid eligibility. This income counting rule effectively raises the upper income eligibility threshold for the new Medicaid eligibility group to 138% FPL.

[12] "Newly eligible" individuals are defined as nonelderly, nonpregnant individuals with family income below 133% FPL who (1) are not under the age of 19 (or such higher age as the state may have elected), and (2) are not eligible under the state plan (or a waiver) for full Medicaid state plan benefits or for Medicaid benchmark or benchmark-equivalent coverage, or are eligible but not enrolled (or are on a waiting list) in such coverage as of December 1, 2009.

among those who were previously eligible but not yet enrolled, as well as increases in administrative costs in the short run.

- Federal requirement to apply reductions in Medicaid disproportionate share hospital (DSH) allotments. While the health reform law is designed to reduce the number of low-income and patients whose care would otherwise be funded in part by DSH payments to hospitals who treat such individuals, with the law's requirement to apply aggregate reductions in DSH payments going forward it remains to be seen if the states will have to finance care that was previously paid in part through federal DSH allotments.
- Federal requirement to increase the amount of Medicaid drug rebates going to the federal government. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the Secretary on behalf of states. Beginning January 1, 2010, with certain exceptions, PPACA increases the flat rebate percentage used to calculate Medicaid's basic rebate by an amount that varies by drug class. PPACA also requires the Secretary to recover the additional funds states received from drug manufacturers from increases in the basic Medicaid rebates (some of which were previously retained by states).

However, there are also a number of changes to Medicaid and CHIP that may offset some of the increased state costs. Some examples include:

- States that currently finance care for childless adults with state-only dollars will now have access to federal matching funds for those individuals under Medicaid.
- With the expiration of the adult coverage MOE requirement in 2014, states may opt to cut back on some of their prior law income eligibility levels for certain groups with annual income greater than 133% FPL, and move them into state exchange coverage where they would be eligible for federal subsidies to share in the cost of their care.
- CHIP allotments were extended through FY2015. This extension guarantees states access to the program's enhanced federal matching rate for two years beyond the prior expiration date of FY2013.
- The law requires states to set Medicaid payments for primary care services relative to Medicare payment rates, and fully finances the payment rate increase for a temporary period (i.e., 2013 and 2014). After this two year period, it is unclear whether states will continue to pay primary care physicians at the higher rate.
- The law also provides additional options for states to expand home and community-based services as an alternative to institutional care and provides states with increased matching rates for certain long-term care services.

Private Health Insurance

PPACA makes significant changes to private health insurance and therefore directly affects multiple stakeholders. States are impacted by the private market provisions through the various roles they play: as sponsors of health benefits to state employees, dependents, and retirees; as administrators of coverage; and financial assistance programs, and as the primary regulators of the insurance industry. Among the major private market provisions in PPACA that permanently affect these state roles are the new federal insurance standards, establishment of health insurance exchanges, and monitoring and enforcement activities related to the regulation of the health insurance industry.

- The federal market reforms that *may* impact private coverage offered to state employees include the prohibition on certain annual and lifetime dollar limits, coverage of preventive health services with no cost-sharing requirements, extension of dependent coverage, use of uniform coverage documents, prohibition of salary-based discrimination, quality of care provisions, reporting of medical loss ratios and rebates, grievance and appeals processes, standards for electronic billing and other administrative transactions, patient protections, and prohibition on excessive waiting periods.[13] Such requirements may add to the cost of coverage in the private market, which, in turn, may affect states' costs related to offering such health benefits.
- PPACA requires the states to establish exchanges (with federal fallback) to facilitate the purchase of private insurance by individuals, families, and small businesses. PPACA provides appropriations (no specified amount), prior to 2015, for state grants to establish and run exchanges. The general assumption is that states will have to provide ongoing funding for exchanges through assessments on insurers or other means, except in those states that fail to establish their own exchange, in which case the HHS Secretary is required to establish it.[14]
- While PPACA does not include specific enforcement provisions, the addition of the federal market reforms discussed above expands the scope of existing state enforcement responsibilities, which may have implications for state costs. In addition, PPACA establishes a federal standard in a regulatory area that has been solely under the jurisdiction of states: review of health insurance rates submitted by insurance carriers. While PPACA requires an insurer to justify "unreasonable" premium increases to both HHS and the relevant state, it is the state's responsibility to review the materials and provide information to the Secretary based on the rate review. PPACA appropriates $250 million in grants to states to support this effort, however total state costs are not known, in part because HHS guidance on the rate review process is still forthcoming and states vary in their existing authority and resources to conduct rate reviews.

However, despite these potential sources of increased state costs, interactions of various provisions may lead to cost offsets in other areas. Examples include:

- The Texas Health and Human Services Commission noted in its presentation to the Texas House Select Committee on Federal Legislation that a potential cost offset resulting from health reform may be increased premium revenue.[15] Estimates of the impact of PPACA on health insurance coverage generally finds substantial growth in private coverage, including through exchanges. Given that states currently generate revenue through

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[13] This list of reforms was generated based on these assumptions: state employee health benefit plans include fully and self-insured plans, and would be provided to large groups only. The list excluded reforms that largely duplicate existing requirements in the group market (e.g., non-discrimination based on health factors), are not permanent (e.g., temporary high-risk health insurance pool), or likely would not have a direct impact on state employee health benefits plans (e.g., guaranteed issue).

[14] On July 29, 2010, HHS issued a Funding Opportunity Announcement (FOA) that announced the availability for the first round of funding for these state grants. Each state and D.C. could apply for up to $1 million in grant money during this first round. The filing date for applications was September 1, 2010. For additional information, see "State Planning and Establishment Grants," at http://www.hhs.gov/ociio/initiative/index.html.

[15] "Federal Health Care Reform – Impact to Texas Health and Human Services," Texas Health and Human Services Commission, April 22, 2010.

premium taxation, growth in private coverage is assumed to lead to increased revenue to states.

- California's Legislative Analyst's Office noted that once the full implementation date of PPACA is reached, the state could likely terminate an existing state-financed health insurance program because other programs under health reform would be established by then.[16]

Analysis

While Medicaid and CHIP differ from private health insurance, both public programs and private coverage share similar challenges with respect to producing state-level cost estimates. Such challenges include pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state preferences regarding implementation; data issues; and factors outside of health reform. The following discussion describes these challenges in more detail and provides examples from Medicaid and CHIP, as well as private health insurance.

Pre-Reform Variation across States

State impacts will vary based on current coverage levels across states, generosity of the state's Medicaid/CHIP eligibility rules and other state-financed coverage programs, existing private insurance regulatory authority, standards, and resources, current state fiscal health, and other factors. Such variation creates difficulties in accurately estimating costs across states.

- There are substantial differences among states in terms of the percentages of the states' populations that would meet the definition of "newly eligible" under the mandatory Medicaid expansion as compared to previously eligible individuals. Federal matching rates to share in the cost of Medicaid/CHIP coverage for these individuals under health reform will vary by state, by year, and by eligibility status. Although from 2014-2016, the federal government will cover 100% of the Medicaid costs of "newly eligible" individuals.
- It could be argued that PPACA will require limited changes to the benefits of state and local government employee health plans, as current employment-based health plans are grandfathered. Grandfathered plans are exempt from all but a handful of reforms under PPACA. That said, it is difficult to assess the impact of the changes that are required, as some requirements may already be in place. For example, one new requirement under PPACA is that children up to age 26 (and until 2014, who are not offered coverage through their own employer) can remain/enroll on their parent's plan. Some plans may not necessarily see a difference because some states already impose requirements beyond age 26, and may continue to do so. For states that do not have a dependent coverage requirement already in place, insurers may see this as adding to the cost of coverage and *may* pass such costs along to consumers and employers (e.g., states as employers providing health benefits to state employees).

[16] "The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs," Legislative Analyst's Office, May 13, 2010.

Federal Guidance to Shape Implementation

State-by-state impacts of PPACA's program and regulatory changes will depend, in part, on future federal guidance and interaction with states in implementing the new law.

- Medicaid program participation rates are among the many moving parts that are relevant in assessing the impacts of PPACA. While PPACA includes provisions to encourage states to improve outreach, streamline enrollment, and coordinate with exchanges, states face mixed fiscal priorities that may inhibit their ability and/or willingness to maximize program enrollment. As a result, federal guidance laying out the minimum requirements in these areas will ultimately affect state costs.
- There is a great deal of uncertainty regarding state costs associated with establishing and running exchanges, in part because HHS has not issued guidance regarding the form and structure of exchanges. Moreover, PPACA appropriated an unspecified amount for the purpose of providing grants to the states for planning and establishment of the exchanges.[17] The grants can be renewed if states comply with specific requirements, but no grant may be awarded after January 1, 2015 when exchanges must be self-sustaining. This lack of specificity regarding the amount of federal funding is another source of uncertainty regarding potential state costs.

State Preferences Regarding Implementation

PPACA provides states with some flexibility regarding implementation of many of the law's coverage provisions. Given that states are still formulating their approach to implementation, this creates uncertainty in the scope of future state activities and associated costs.

- PPACA gives states some flexibility regarding implementation and operation of exchanges. A state may opt to have HHS establish its exchange. States also have the option to establish separate exchanges for individuals and small businesses, or establish just one exchange for both. Individual states also may decide to allow large businesses in the exchange. These decisions, individually and collectively, may impact state spending on exchanges.
- The PPACA insurance reforms do *not* uniformly apply to all employer-provided coverage. The type of plan matters with respect to which market reforms it must comply with. For example, a self-insured plan does not have to comply with the medical loss ratio provisions, but a fully-insured plan does.[18] Thus, the decision states make in

[17] See footnote 14.

[18] Organizations that self-insure (or self-fund) do not purchase health insurance from an insurance carrier. Self-insurance refers to coverage that is provided by the organization seeking coverage for its members (e.g., an employer offering health benefits to his employees). Such organizations set aside funds and pay for health benefits directly. (Enrollees may still be charged a premium.) Under self-insurance, the organization itself bears the risk for covering medical expenses. Firms that self-fund health benefits typically contract with third-party administrators to handle administrative duties such as enrollment, premium collection, customer service, and utilization review. With fully insured plans, the insurance carrier charges the plan sponsor (e.g., employer) a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. (In turn, the sponsor may decide that each person or family who wishes to enroll must pay part of the premium cost.) Under the fully insured scenario, the insurance carrier bears the insurance risk; that is, the carrier is responsible for covering the applicable costs associated with covered benefits.

funding employee health benefits plans has implications for what insurance reforms such plans are subject to. As mentioned previously, insurers may see these additional requirements as adding to the cost of coverage and *may* pass such costs along to consumers and employers in the form of higher premiums (or higher cost-sharing or reduced benefits).

Data Issues

Data issues range from limitations of existing data sources to a lack of data.

- Some state specific cost estimates use national surveys such as the Current Population Survey (CPS), the American Community Survey (ACS) or the National Health Interview Survey (NHIS) to simulate eligibility for Medicaid, CHIP, or exchange subsidies. However, these national surveys have their own limitations many of which have been well documented and acknowledged by the Census Bureau and other research organizations.[19] For example, the CPS and NHIS have historically undercounted Medicaid enrollees and are less reliable for small states.[20] With much larger sample sizes than that of the CPS or NHIS, the ACS does a better job of reducing error associated with small sample size. However, regardless of the survey used, discrepancies exist between survey estimates of enrollment in Medicaid and the number of enrollees reported in state and national administrative data.
- Given that so many aspects of exchanges are as of yet not known, costs cannot be attributed to the various components with a sufficient degree of confidence. In addition, the exchanges, as specified in the statute, are new entities. While a few states have created similar entities, none have the federal-state design of those established under PPACA. Therefore, there is no dataset from an existing program that could be used to accurately model the initial experience of the exchanges. This contrasts with, for example, the Medicaid program, which has existed for many years and has past administrative data that provides a baseline for state costs.

Factors Outside of Health Reform

Given that health insurance coverage in the U.S. traditionally has been linked with employment, changes in the labor market generally lead to changes in coverage rates. Typically, when the general economy is in decline and unemployment rises, individuals and families lose access to their primary source of insurance. Data on coverage trends typically find that when employment-based coverage decreases, enrollment in

[19] For links to the results of research projects conducted by the University of Minnesota's State Health Access Data Assistance Center (SHADAC), the National Center for Health Statistics (NCHS), the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare and Medicaid Services (CMS), and the U.S. Census Bureau to explain why discrepancies exist between survey estimates of enrollment in Medicaid and the number of enrollees reported in state and national administrative data, see http://www.census.gov/did/www/snacc/

[20] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," Current Population Reports P60-236(RV), Washington, DC, 2009, at [http://www.census.gov/prod/2009pubs/p60-236.pdf], p. 20, and p. 57.

Medicaid increases.[21] The public-private mix of enrollment will affect state spending related to both types of coverage.

CRS contacts:

Medicaid: Evelyne Baumrucker (7-8913), April Grady (7-9578)

Private Health Insurance: Bernadette Fernandez (7-0322), Mark Newsom (7-1686), Hinda Chaikind (7-7569).

[21] "Losing a job often means that people lose health insurance. Many individuals, especially children will become eligible for Medicaid…We estimate that if unemployment rises from an average of 4.6 percent in 2007 to 7 percent in 2009, the number of people with employer sponsored insurance (ESI) would decline by 5.9 million, Medicaid and SCHIP enrollment would increase by 2.4 million and there would be an additional 2.6 million uninsured." John Holahan and A. Bowen Garrett, "Rising Unemployment, Medicaid, and the Uninsured," Jan. 2009, p. i.

Appendix

Table 1. State-Specific Analyses of PPACA's Impact on State Costs

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
California	"The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs" Provides an estimate of the impact of PPACA on Medicaid enrollment and state spending on Medicaid. Cost estimate attributed to increase in Medicaid enrollment, accounting for eligible but not enrolled and expansion populations (eligibility up to 133 percent FPL and former foster children), and increased primary care provider payments. Prepared by the Health Section of the Legislative Analyst's Office, a state governmental office providing fiscal and policy information to the California Legislature. http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.pdf	2,000 (no timeframe provided)	N/A	"low billions of dollars" (annual)
Florida	"Overview of National Health Reform Legislation" Provides an estimate of the impact of PPACA on enrollment in the state's Medicaid and CHIP programs and the increase in Medicaid primary care provider payments. Does not include impacts associated with increases in administration costs, changes to the federal pharmacy rebate or changes to state disproportional share hospital payment allowances. Takes into account potential shift of individuals with annual income <133% FPL who are currently enrolled under private health plans to shift to the Medicaid program. Assumes CHIP children with annual income <133% FPL will shift to Medicaid program. Assumes SFY 2012-2013 Medicaid expenditures program expenditures and caseloads for non- expansion populations and uses Census data increase by 1.6% through 2014 for expansion population. Prepared by The Agency For Health Care Administration, the chief health policy and planning entity for the state.	1,772 (by 2019)	N/A	$1,203 (by 2019)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
	http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_040110.pdf			
Indiana	"Patient Protection and Affordable Care Act with House Reconciliation – Financial Analysis" Provides a financial review of PPACA as it relates to the provisions impacting the state's Medicaid program and budget. The study considered the following components when generating their assessment of the impacts of health reform on the state budget: the Medicaid Expansion to 133% FPL, the impact of the reduced federal medical assistance percentage (FMAP) rate for their Healthy Indiana Plan eligibles, spend down and their SSI eligible population, the state's projected pharmacy rebate loss, the impact of the physician fee schedule increase, the mandatory expansion to foster care children, administrative costs, the enhanced match rate under the CHIP program, the state's current thoughts on the treatment of their Breast and Cervical Cancer program and pregnant women coverage for individuals with annual income greater than 133% FPL at full implementation. Prepared by Milliman, Inc., a consulting service retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to the financial review of PPACA. http://www.in.gov/fssa/files/Milliman_financial_analysis_May2010.pdf	1,554 (SFYs 2011 through 2020)	N/A	$3,579 (SFYs 2011 through 2020)
Kansas	"Preliminary Estimates of the Impact of Federal Health Reform on State Spending in Kansas" Provides preliminary estimates of the impact of PPACA on state spending in Kansas. Estimates represent the most likely outcome of PPACA reforms. Assumes state takes no additional actions to expand coverage or reduce spending, and increased costs in program administration. Cost estimate is for spending on medical care only in the Medicaid program. Excludes administrative costs and changes in DSH spending. Estimates are expressed in constant dollars using 2011 as a base. Prepared by the Kansas Health Policy Authority, an independent Board comprised of members selected by the Governor and the leadership of the state legislature to provide governance and thoughtful policy direction for the state's health care-related agenda. http://www.khpa.ks.gov/ppaca/download/Impact%20of%20Federal%20Health%20Reform%20on%20Kansas%20-%20allison%20presentation.pdf	131 (by 2020)	191 (by 2020)	$621 (by 2020)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
Kansas	"Kansas: Impact of Federal Health Reform" Provides presentation of preliminary estimates of PPACA's impact on coverage and state costs based on 4 scenarios. Four scenarios modeled using two different counts of remaining uninsured (98,000 and 143,000) and two different provider reimbursement rate increases (0% increase and 5% increase). Medicaid enrollment includes both Medicaid and CHIP, according to just one of the scenarios modeled. Study did not attribute the cost estimate to any particular program or coverage initiative. It is unclear what this state costs estimate represents. Prepared by Schramm-Raleigh Health Strategy for the Kansas Health Policy Authority, the state's main health policy agency. http://media.khi.org/news/documents/2010/05/18/5-18-10_SRHealth_Presentation.pdf	120 ("post-reform")	191-237 ("post-reform")	$2-36.3 ("post-reform")
Maryland	"Interim Report" Provides estimates of PPACA's impact on the uninsured rate and costs associated with changes to both public and private coverage. Savings estimate is the net result of cost increases due to Medicaid expansion, increased spending for state employee/retiree health benefits, and administrative costs (e.g., establishing exchange), and revenue growth/savings from increased federal support of state's CHIP program, new hospital assessments, increased premium taxation revenue, and reduction in state funding for safety net programs. Prepared by the state's Health Care Reform Coordinating Council for submission to the Governor. http://www.healthreform.maryland.gov/documents/100726interimreport.pdf	N/A	Decrease of 7.3 percentage points (by 2017)	Savings of $829 (FY 2011-2020)
Michigan	"Fiscal Analysis of the Federal Health Reform Legislation" Examines the fiscal impacts of PPACA on state and local government in Michigan. Assumes a Medicaid federal matching rate of 66.7%. Discusses the cost to the state to continue the Medicaid primary care physician payment rates at the Medicare levels beyond the two years during which the federal government will fully fund this payment rate increase, but not clear if these amounts are included in the state's expenditure estimate. Provides impacts on the CHIP program beyond the	375 (by 2019)	N/A	$200 (by 2019)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
	PPACA funding (i.e., through FY2015) appropriation, but it is unclear if these amounts are included in the state's expenditure estimates. Acknowledges impacts of Medicaid drug rebate provisions, but does not provide a state specific cost estimate of the impacts. Acknowledges the potential impacts of the various long-term care related provisions and provisions directed at increasing care coordination, encouraging more use of health prevention, and improving the quality of care. However, the state did not report a dollar figures associated with these potential costs. Acknowledges impacts of Medicaid DSH reduction provisions, but does not provide a state specific cost estimate of the impacts. Prepared by the Senate Fiscal Agency whose role is to provide technical, analytical, and preparatory support to the state's Senate Appropriation Committee and other members of the Senate. http://www.senate.michigan.gov/sfa/Publications/Issues/HealthReform/FedHealthReformLegislation.pdf			
North Dakota	Provides preliminary estimates of the overall cost of implementing health reform. The cost estimates are based on the following assumptions: current enrollees in private market will remain in grandfathered plans (based on Blue Cross/Blue Shield enrollment that represents 80+% of the market) throughout the study period (2010-2019), and all covered public-sector employees will remain in grandfathered plans through that period. The cost estimate does not include possible offsets from grants or subsidies. The analysis states that "estimates should be used with caution, as amounts will change when additional guidance and policy decisions are made at the federal level." Prepared for North Dakota's Industry, Business, and Labor Committee. http://www.legis.nd.gov/assembly/61-2009/interim-info/minutes/ib080310minutes.pdf	N/A	N/A	$1,114 (2010-2019)
Texas	"Federal Health Care Reform – Impact to Texas Health and Human Services" Discusses PPACA requirements, describes model, and provides estimates of PPACA's impact on enrollment in and state spending on Medicaid. The enrollment estimate includes the eligible but not enrolled and Medicaid expansion populations. The cost estimate includes costs associated with the eligible but not enrolled and Medicaid expansion populations, and full rate increases for primary care providers. The provider rate increase is assumed to apply to both Medicaid and CHIP. Prepared by the Texas Health and Human Services Commission for the House Select Committee on Federal Legislation.	2,345 (by 2023)	N/A	$27,000 (SFY 2014-2023)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)

http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf

Source: CRS analysis of existing state-level cost analyses prepared by a variety of organizations including: (1) state the Agencies that administer Medicaid and/or the State Children's Health Insurance Program (CHIP), (2) state legislature support agencies, (3) independent consultants retained by the state to provide a financial review of the impacts of PPACA on the state's budget, and (4) organizations (e.g., independent Boards established by the state legislature) whose role is to provide input into policy and planning for the state.

Table 2. Summary of Published Estimates of the Impact of PPACA's Coverage Provisions on Medicaid and CHIP

Study (publication date)	Summary of Analysis	Estimates of Increase in Medicaid Enrollment in millions (time frame)	Expenditure Estimates in billions (time frame)		Selected Assumptions
			Overall State Spending	Federal Spending	
CBO Cost Estimate (March 2010)[a]	National estimate of effects of all of the insurance coverage provisions in health reform on Medicaid/CHIP	16 million (by CY2019)	$20 billion[b] (FY2010-2019)	$434 billion (FY2010-2019)	Detailed assumptions not provided in cost estimate.
Kaiser Commission on Medicaid and the Uninsured (May 2010)[c]	State-by-state[c] estimates of impact of coverage provisions on Medicaid/CHIP for adults relative to enrollment and spending on such adults in absence of health reform for the period between 2014 and 2019.	15.9 (CY2014-CY2019)	$21.1 (CY2014-2019)	$443.5 (CY2014-2019)	Assumes moderate (57%) participation levels among uninsured in the new eligibility group and lower participation among other coverage groups.
		22.8 (CY2014-CY2019)	$43 (CY2014-2019)	$532 (CY2014-2019)	Assumes robust (75%) participation levels among uninsured in the new eligibility group, and lower participation among other coverage groups.

Source: CRS analysis of various national estimates of the impacts of PPACA's coverage provisions on Medicaid and CHIP enrollment and spending.

Notes:

a. Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010.

b. The Congressional Budget Office does not prepare state-by-state estimates.

c. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010.

d. The Kaiser report shows results for three general groupings (i.e., states with low prior law Medicaid eligibility rates for adults, states that have broader prior law coverage for parents, but no coverage for childless adults, and states that cover both parents and childless adults under prior law). See the report for trends by state groupings as well as state-by-state results.

Exhibit 6

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

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

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

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF BRUCE R. RAMGE

Pursuant to 28 U.S.C. § 1746, I, Bruce R. Ramge, declare the following:

1. My name is Bruce R. Ramge. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Nebraska Department of Insurance (NDOI) as the Director.

2. I have served as Director of Insurance since November 15, 2010. Previously, I was Acting Director from October 30, 2010 through November 14, 2010. Prior to October 30, 2010, I served in the capacity of Deputy Director and Chief of Market Regulation.

3. As the Director of Insurance, I am the highest ranking official at the NDOI and oversee all activities of the Agency including the regulatory oversight of the Comprehensive Health Insurance Pool (CHIP).

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I reviewed the Defendants' claim that the PPACA will save the State of Nebraska approximately $27 million per year beginning in 2014 when the CHIP program ends with the individuals insured obtaining insurance through a proposed exchange. This is based on a report by the Executive Office of the

President, Council of Economic Advisors, dated September 15, 2009 (CEA Report, page 67).

6. The State of Nebraska does not subsidize premiums for the CHIP program. Under Nebraska law, the state is required to subsidize claims exceeding the amount collected in premiums from the CHIP members. In 2008, this amount was $27,375,209. In 2009, this amount was $24,051,163.

7. The provisions of PPACA currently anticipate the transfer of CHIP participants to Medicaid or health insurance products offered through a proposed exchange beginning January 1, 2014. A number of factors prevent me from predicting, at this time, the precise impact the transfer of CHIP participants to Medicaid will have on the State of Nebraska in 2014, including: claims in process, incurred but not reported claims, and the remaining administrative and wrap up costs. However, said transfer is not anticipated to be a cost savings for the State of Nebraska due to the additional burden of enrolling such individuals in the Medicaid system.

8. With the influx of CHIP policyholders who may purchase insurance through an exchange, the health insurance premium charged to all persons obtaining coverage through the exchange will necessarily increase to cover high claim individuals. Essentially, the experience of the high claim individuals will be reflected in the price of the premium for individual insurance coverage offered in Nebraska generally resulting in higher premium costs for all participating in an exchange. This results in a cost shift to all citizens of Nebraska purchasing through the exchange via an increase in premium costs.

9. Further, individual coverage in the exchange may become so costly that the CHIP policyholders will not be able to afford it even with a subsidy for which the CHIP policyholder may be eligible. An unknown number of current CHIP policyholders may also qualify for Medicaid, resulting in an increase in costs incurred by the state.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Lincoln, Nebraska.

Bruce R. Ramge

Bruce R. Ramge
Director, Nebraska Department of Insurance

Exhibit 7

kaiser commission on medicaid and the uninsured

Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories

prepared by

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Arunabh Ghosh, B.A.
The Urban Institute

and

David Rousseau, M.P.H.
The Kaiser Commission on Medicaid and the Uninsured

June 2005

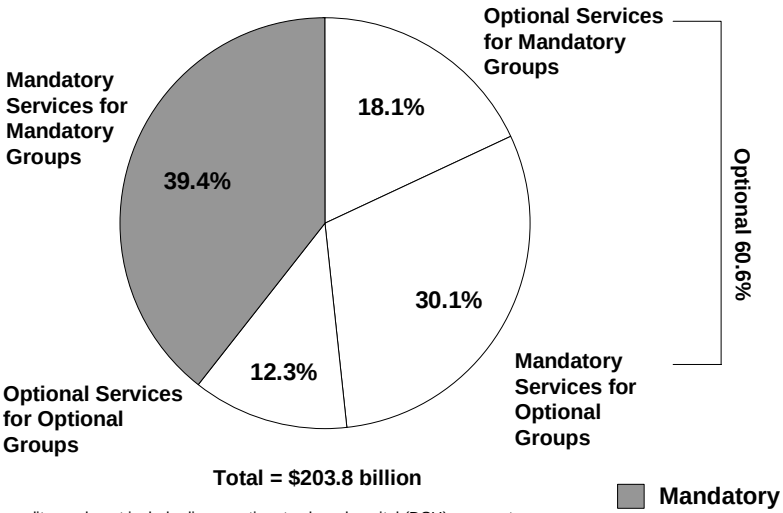
THE HENRY J. KAISER FAMILY FOUNDATION

Mandatory and Optional Medicaid Spending

In 2001, Medicaid spent $203.8 billion on acute and long-term care services for low-income families, individuals with disabilities, and the elderly (Figure 4). This includes $5.0 billion of mandatory payments to Medicare for individuals dually eligible for Medicaid and Medicare, in the form of premiums, copayments, and coinsurance. Of the $203.8 billion in Medicaid expenditures, 39.4% was mandatory, or spending on mandatory benefits for mandatory eligibility groups. The remaining 60.6% was considered optional spending: 18.1% of spending was on optional benefits for mandatory groups, 30.1% was for mandatory benefits for optional groups, and 12.3% was for optional benefits for optional groups.

Figure 4

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

A total of $80.4 billion was spent on mandatory services for mandatory groups in 2001 (Figure 5). The vast majority of mandatory spending, 78 percent or $62.6 billion, was attributable to acute care services other than prescription drugs. Over 90% of these expenditures were attributable to "major" acute care services, defined as inpatient, outpatient hospital, physician, lab/x-ray, clinic, and managed care services. Long-term care accounted for 16% of all mandatory spending, of which just over half (54%) was for nursing facility care. Payments to Medicare for premiums and coinsurance for mandatory dual eligible individuals accounted for nearly 4% of mandatory spending.

A total of $123.4 billion was spent on optional services for mandatory groups combined with all spending for optional groups in 2001 (Figure 5). Nearly sixty percent of all of this optional spending (57.3%) was attributable to long-term care. Payments to Medicare for premiums and coinsurance for optional dual eligible