No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR RESPONDENTS (Medicaid)

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QUESTION PRESENTED

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, eligibility for Medicaid shall extend to certain individuals with income up to 133% of the federal poverty level. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2010).

The question presented is whether the extension of Medicaid eligibility is a valid exercise of Congress's power to set the terms on which it will appropriate federal funds.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-273a[1]) is reported at 648 F.3d 1235. The district court's opinion on the federal government's motion to dismiss (Pet. App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on the parties' cross-motions for summary judgment (Pet. App. 274a-368a) is reported at 780 F. Supp. 2d 1256.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The petition for a writ of certiorari

[1] All citations are to the appendix to the federal government's certiorari petition in No. 11-398.

was filed on September 27, 2011, and was granted on November 14, 2011. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional and statutory provisions are set forth in the appendix to this brief. App., *infra*, 1a-26a.

STATEMENT

A. Statutory Background

1. The Medicaid Act, enacted in 1965 in Title XIX of the Social Security Act (SSA), 42 U.S.C. 1396 *et seq.*,[2] establishes a cooperative federal-state program to fund medical care for needy individuals. Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121(a), 79 Stat. 343; see *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 275 (2006). "States are not required to participate in Medicaid, but all of them do." *Ibid.*

"The Federal Government shares the costs of Medicaid with States that elect to participate in the program. In return, participating States are to comply with requirements imposed by the Act and by the Secretary of Health and Human Services." *Atkins* v. *Rivera*, 477 U.S. 154, 156-157 (1986). "Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of the [Medicaid Act]." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see also *Frew* v. *Hawkins*, 540 U.S. 431, 433 (2004) ("State participation is voluntary; but

[2] Unless otherwise indicated, all citations to the United States Code refer to the 2006 edition and Supplement IV (2010).

once a State elects to join the program, it must administer a state plan that meets federal requirements.").

To be eligible for federal funds, a State that elects to participate in the Medicaid program must submit a plan to the Secretary of Health and Human Services (HHS) that meets the Medicaid Act's requirements. 42 U.S.C. 1396a. If the Secretary approves a state plan (or plan amendment), the federal government reimburses the State for a percentage of qualified Medicaid expenses. The federal contribution rate generally falls between 50% and 83%, depending on a State's per capita income. 42 U.S.C. 1396d(b).

Since Medicaid's enactment in 1965, the basic terms of the program have required participating States to fund the provision of certain health care benefits to specific categories of needy individuals. See 42 U.S.C. 1396a(a)(10); *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 650-651 & n.4 (2003). Participating States must also comply with various administrative requirements, including requirements that protect the Medicaid program from waste, fraud, and abuse, *e.g.*, 42 U.S.C. 1396a(a)(69); protect the health and safety of Medicaid beneficiaries, *e.g.*, 42 U.S.C. 1396a(a)(9); protect the privacy of beneficiary information, 42 U.S.C. 1396a(a)(7); and ensure that payments for care and services are sufficient to accomplish the goals of the program, 42 U.S.C. 1396a(a)(30)(A) (the provision at issue in *Douglas* v. *Independent Living Center*, No. 09-958, and consolidated cases (argued Oct. 3, 2011)). In addition, state Medicaid programs must comply with federal civil rights statutes applicable to programs that receive funding from HHS. See, *e.g.*, 45 C.F.R. Pt. 80 (implementing Title VI of the Civil Rights Act of 1964); 45

C.F.R. Pt. 84 (implementing Section 504 of the Rehabilitation Act of 1973).

Beyond those minimum requirements, States may choose to cover additional categories of enrollees and to provide additional medical benefits, generally at the same rate of federal reimbursement. See, *e.g.*, 42 U.S.C. 1396a(a)(10)(A)(ii) and (C). Every State has elected to extend eligibility to some optional populations and to cover some optional benefits. See Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options*, App. B, Tbl. 1, at 4 (Jan. 2012) (*Medicaid Enrollment and Expenditures*). By 2007, the cost of the coverage States chose to provide to optional beneficiaries and for optional benefits had grown to account for approximately 60% of all Medicaid spending. *Id.* at 1.

The Secretary enforces state compliance with federal Medicaid requirements. The Medicaid Act provides that if, after giving a State notice and an opportunity for a hearing, the Secretary finds that the State is failing to comply substantially with a provision of the Medicaid Act, the Secretary shall notify the State "that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. 1396c. Under the implementing regulations, before holding a hearing, the Secretary generally must first make reasonable efforts to resolve an issue of compliance with a State. 42 C.F.R. 430.35, 430.70.

2. In the Social Security Act, 42 U.S.C. 301 *et seq.*, of which the Medicaid Act is a part, Congress expressly reserved the "right to alter, amend, or repeal any provi-

sion" of the Act. 42 U.S.C. 1304; see *Bowen* v. *Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 44 (1986). Each State Medicaid plan expressly provides that its plan "will be amended whenever necessary to reflect * * * [c]hanges in Federal law." 42 C.F.R. 430.12(c)(1)(i) (requiring all States participating in Medicaid to include such provisions in their plans); see, *e.g.*, Florida Agency for Health Care Admin., *State Plan Under Title XIX of the Social Security Act Medical Assistance Program* § 7.1, at 86 (Oct. 6, 1992). Consistent with the Act's express reservation of authority, Congress has amended the Medicaid Act many times since 1965, and has frequently expanded the scope of mandatory eligibility as well as the definition of mandatory benefits.

When Medicaid was first established in 1965, the program required participating States to provide medical assistance to individuals receiving welfare benefits under one of four federal programs administered by the States: Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, or Aid to the Permanently and Totally Disabled. See 42 U.S.C. 1396a(a)(10) (1970); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981). In 1972, Congress replaced the latter three programs with Supplemental Security Income for the Aged, Blind, and Disabled (SSI). *Id.* at 38 (citing Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1465). Under the SSI program, Congress "displaced the States by assuming responsibility for both funding payments and setting standards of need." *Ibid.* The effect in some States was to extend Medicaid eligibility, according to federal standards of need, to individuals who had not previously been eligible under standards set under state-run programs. *Ibid.* Con-

gress provided, however, that States could elect to limit the expansion of Medicaid as long as they maintained eligibility for individuals who would have been eligible under the state Medicaid plan in effect on January 1, 1972 (the "209(b) option"), based on standards set under state-run welfare programs. States that elected the 209(b) option were required not only to maintain then-current levels of Medicaid eligibility, but also "to adopt a 'spend-down' provision" under which "an individual otherwise eligible for SSI but whose income exceeded the state standard could become eligible for Medicaid when that part of his income in excess of the standard was consumed by expenses for medical care." *Id.* at 38-39 & nn.4 & 5. A minority of States exercised that option. *Id.* at 39 n.6. Thus, under either the SSI expansion or the 209(b) option, States choosing to participate in Medicaid were obligated to provide coverage to substantial numbers of individuals not included within the scope of mandatory coverage before the 1972 amendment.

Beginning in the 1980s, Congress expanded Medicaid eligibility beyond individuals receiving cash welfare assistance. See generally John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105, 108 (Fall 2000). "The expansions affected nearly the entire spectrum of Medicaid enrollees from infants, children, and pregnant women to low-income Medicare beneficiaries, and other aged and disabled enrollees." *Ibid.* States were initially given the discretion to offer coverage to these groups, but subsequent legislation made the expanded eligibility mandatory for States that chose to participate in Medicaid. *Ibid.*; see, *e.g.*, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2258 (extending eligibility to

pregnant women and children under age six, with household income up to 133% of the federal poverty level); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388-166 (extending eligibility to children aged 6 through 18 with household income up to 100% of the federal poverty level). At each step in the process of expanding eligibility, every State elected to continue participating. As of 2008, Medicaid provided coverage to approximately 47 million Americans. Centers for Medicare & Medicaid Servs., HHS, *2010 Actuarial Report on the Financial Outlook for Medicaid* Tbl. 3, at 19 (Dec. 21, 2010) (*2010 Actuarial Report*).

Despite these expansions, many low-income individuals have remained ineligible for Medicaid (and unable to afford health care on their own). Adults under age 65 who are not caring for dependent children and who are not pregnant or disabled have generally been ineligible for Medicaid, no matter their income. See 42 U.S.C. 1396d(a) (listing categories of persons eligible for medical assistance).[3] For parents caring for dependent children, eligibility standards have varied by State, but as of January 2012, the median eligibility cap was 37% of the federal poverty level for unemployed parents and 63% of the federal poverty level for parents who have earnings. Kaiser Comm'n on Medicaid and the Uninsured, *Performing Under Pressure: Annual Findings*

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[3] Some States have received authorization to carry out renewable "demonstration projects" under which they have extended coverage to these adults. See 42 U.S.C. 1315 (authorizing the Secretary to waive certain requirements for state plans under the Medicaid Act to allow States to carry out certain demonstration projects); CMS, *Medicaid and CHIP Program Information: Waivers*, http://www.medicaid. gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (providing information about state demonstration projects).

of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP 2011-2012, at 11 & Fig. 11 (Jan. 2012). And, even though States, at their option, could receive federal Medicaid funds to cover parents at higher income levels, 17 States have limited Medicaid eligibility for working parents to parents with incomes below 50% of the federal poverty level. *Ibid.*

3. Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act),[4] to address a crisis in the national health care market that exists because tens of millions of Americans cannot afford health insurance and thus cannot reliably obtain adequate health care.

One of the principal means by which Congress addressed the crisis was by extending Medicaid eligibility to certain individuals under 65, not receiving Medicare, and with incomes up to 133% of the federal poverty level. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).[5] The persons

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[4] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

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

Petitioners' reference to 138% (rather than 133%) of the federal poverty level, States' Br. 7, reflects Congress's adjustments to the use of "income disregards" in determining Medicaid eligibility. Historically, States used income disregards to exclude certain amounts of income when evaluating an applicant's eligibility for medical assistance. Those disregards varied from State to State, and had the effect of raising the eligibility ceiling for such programs. To achieve consistency, Congress in the Affordable Care Act generally eliminated the use of disregards other than a standard 5% income disregard and prescribed a new modified adjusted gross income standard to be used in determining eligibility. 42 U.S.C. 1396a(e)(1)(A), (B), (D) and (I). See generally

made newly eligible for Medicaid are primarily low-income adults under age 65 who are not disabled and do not have children. See Congressional Budget Office, *CBO's 2011 Long-Term Budget Outlook* 38 (June 2011) (*Budget Outlook*).

The Affordable Care Act does not require States to provide the traditional Medicaid benefit package to individuals covered by the eligibility expansion, instead applying the Medicaid Act's "benchmark" or "benchmark-equivalent" coverage provisions. 42 U.S.C. 1396a(k)(1); see 42 U.S.C. 1396u-7(b). Under those provisions, States must provide coverage that includes defined health benefits and meets certain other requirements, but may choose options that may be less comprehensive than the traditional Medicaid benefit package. *Ibid.*

The federal government will bear nearly the entire cost of medical assistance for individuals made newly eligible by the Affordable Care Act. From 2014 through 2016, the federal government will pay 100% of the costs of providing medical assistance associated with the extension of eligibility. 42 U.S.C. 1396d(y). That amount will gradually decrease, to 95% in 2017, 94% in 2018, and 93% in 2019. *Ibid.* In 2020 and thereafter, the federal government will pay 90% of these costs. *Ibid.* That level of support significantly exceeds the typical federal contribution rates, which range from 50% to 83% of a State's Medicaid expenditures and which have generally averaged 57%. See 42 U.S.C. 1396d(b); *2010 Actuarial Report* 20.

Kaiser Comm'n on Medicaid & the Uninsured, *Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP* (May 2008).

Moreover, although the federal government ordinarily pays 50% of most state administrative costs, 42 U.S.C. 1396b(a)(2)-(5) and (7), through 2015 the federal government will pay 90% of state administrative expenses incurred to upgrade state information systems for making eligibility determinations. See 76 Fed. Reg. 21,950 (Apr. 19, 2011).

The Congressional Budget Office (CBO) has projected that state Medicaid spending will increase by $20 billion between 2010 and 2019 as a result of the Affordable Care Act, as compared to an increase in federal Medicaid spending of $434 billion over the same period. Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, United States House of Representatives Tbl. 4 & n.c (Mar. 20, 2010) (CBO Letter); see States' Br. 10. The projected increase is approximately 0.8% above what States were projected to have spent on Medicaid without the Affordable Care Act. See CBO, *Spending & Enrollment Detail for CBO's March 2009 Baseline: Medicaid* (*2009 Baseline Spending and Enrollment Detail*).[6]

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[6] Without the Affordable Care Act, federal Medicaid payments between 2010 and 2019 were projected to total approximately $3.3 trillion and to constitute 57% of total Medicaid spending. *2009 Baseline Spending and Enrollment Detail*. State Medicaid spending in the absence of the Affordable Care Act was projected to account for the remaining 43%, *ibid.*, or $2.47 trillion.

Petitioners cite (States' Br. 10) another study estimating that increased state spending will range from $21.1 billion to $43.2 billion, depending on the rate of increased enrollment. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* 19-20, 23 (May 2010). Even at the high end of that range, the projected increase would represent an increase of approximately

That 0.8% increase in state Medicaid spending will likely be more than offset by other savings States will achieve as a result of the Affordable Care Act's reforms. The Act will reduce state costs by, for example: shifting certain adults from optional Medicaid coverage to health insurance bought through the health insurance exchanges (with the assistance of federal premium tax credits and cost-sharing reductions), or to Medicaid coverage at a more advantageous federal matching rate; and shifting coverage of mental-health benefits from wholly state-funded programs to Medicaid. See Matthew Buettgens, Stan Dorn & Caitlin Carroll, *Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019*, at 1-10 (July 2011) (*Consider Savings*). In addition, the Act will alleviate the burden on States to pay for the uncompensated care that millions of currently uninsured individuals consume each year. See *id.* at 10; Gov't Minimum Coverage Br. 7-8, 33-37. As a result of these and other effects, studies project that, under the Affordable Care Act, overall state spending will be approximately $100 billion lower through 2019 than it would have been without the changes made by the Act.[7]

1.75% over what States were projected to have spent on Medicaid without the Affordable Care Act.

[7] *Consider Savings* at 4-5 (projected state savings of $92 to $129 billion between 2014 and 2019); The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* 32 (June 2010) (projected state and local government savings of approximately $107 billion between 2010-2019); see also Stan Dorn & Matthew Buettgens, *Net Effects of the Affordable Care Act on State Budgets*, Tbl. 1, at 2 (Dec.

4. In a separate title of the Affordable Care Act, Congress provided that, beginning in 2014, non-exempted individuals who fail to maintain a minimum level of health insurance coverage for themselves or their dependents will owe a tax penalty for each month in the tax year during which that minimum coverage is not maintained. 26 U.S.C. 5000A(a) and (b). As a result of the Act's design, individuals who would otherwise be eligible for Medicaid would not face a tax penalty for failure to purchase health insurance in the event that a State elects to opt out of Medicaid. Low-income individuals who are not required to file federal income tax returns for a given year are not subject to the tax penalty that is the only consequence of failing to maintain minimum coverage.[8] Congress also exempted, *inter alia*, individuals whose premium payments would exceed 8% of their household income and individuals who establish that obtaining coverage would be a hardship under standards to be set by the Secretary of HHS. 26 U.S.C. 5000A(e). In addition, Congress provided that, beginning in 2014, applicable taxpayers can receive federal premium tax credits to help them purchase insurance through a health insurance exchange. 26 U.S.C. 36B(a).[9]

2010) (concluding that States can realize savings of $40.6 to $131.9 billion between 2014 and 2019).

[8] Generally, for 2011, the threshold for filing income tax returns is $9500 in gross income for a single taxpayer under the age of 65; $12,200 for a head of household under 65; and $19,000 for a married couple under 65 filing jointly. See IRS, *Publication 501: Exemptions, Standard Deduction, and Filing Information* 2-3 & Tbl. 1 (2011), http://www.irs.gov/pub/irs-pdf/p501.pdf.

[9] See 26 U.S.C. 36B(c)(1)(A) (defining "applicable taxpayer" as a taxpayer with household income between 100% and 400% of the federal poverty level), (c)(1)(B) (special rule authorizing federal premium tax

B. Proceedings Below

Petitioners are 24 States, a state attorney general, and a governor. They filed suit in the Northern District of Florida, alleging, as relevant here, that the Affordable Care Act's extension of Medicaid eligibility is not a valid exercise of Congress's power to set the terms on which it will appropriate federal funds. Petitioners argued that the Medicaid program is "coercive" because it would be too disadvantageous for them to withdraw, given the amount of money the federal government provides to fund the provision of health care to their low-income citizens.

Rejecting that argument, the district court explained that "state participation in the Medicaid program under the [Affordable Care] Act is—as it always has been—voluntary." Pet. App. 283a. The district court further explained that petitioners failed to offer a "judicially manageable standard or coherent theory" for deeming a federal spending program to be "coercion," and that "every single federal Court of Appeals called upon to consider the issue has rejected the coercion theory as a viable claim." *Id.* at 285a (citing cases).

The court of appeals affirmed in relevant part. Pet. App. 50a-63a. The court reasoned that this Court's decision in *South Dakota* v. *Dole*, 483 U.S. 203 (1987),

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credits for qualified aliens lawfully present in the United States with income less than 100% of the federal poverty level who are not eligible for Medicaid because of their alien status), (c)(2)(B)(i) (providing exception for any coverage month in which "the individual is eligible for minimum essential coverage other than eligibility for coverage described in [26 U.S.C. 5000A(f)(1)(C)] (relating to coverage in the individual market)," which includes months during which an individual is eligible for Medicaid because, *inter alia*, her income is less than 133% of the federal poverty level).

"instructs * * * that Congress cannot place restrictions so burdensome and threaten the loss of funds so great and important to the state's integral function as a state—funds that the state has come to rely on heavily as part of its everyday service to its citizens—as to compel the state to participate in the 'optional' legislation." Pet. App. 60a. The court opined that "[t]his is the point where 'pressure turns into compulsion.'" *Ibid.* (quoting *Dole*, 483 U.S. at 211, and *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 590 (1937)). Observing that "no court has ever struck down a law such as this one as unduly coercive," *id.* at 58a, the court concluded that several factors demonstrate that "the Act's expansion of Medicaid is not unduly coercive under *Dole* and *Steward Machine*," *id.* at 60a. The court explained that Congress expressly reserved the right to alter the Medicaid program, see 42 U.S.C. 1304, and that, since the program's inception, Congress has enacted several mandatory extensions of Medicaid eligibility. Pet. App. 60a-61a. The court also noted that the federal government will bear nearly all of the costs associated with the Affordable Care Act's expansion of Medicaid eligibility; that the Affordable Care Act gave States ample notice—nearly four years from when the legislation was enacted—to determine whether to continue to participate in the Medicaid program; and that States are free to establish their own programs if they do not want to accept the terms offered under the federal program. *Id.* at 61a-62a. And finally, the court explained that the Medicaid Act gives HHS discretion to withhold part or all of Medicaid funding from a State that does not comply with the Act's requirements. *Ibid.* (citing 42 U.S.C. 1396c). In light of those considerations, the court concluded that "the Medicaid-participating states have a real choice—not

just in theory but in fact—to participate in the Act's Medicaid expansion." *Id.* at 63a.

SUMMARY OF ARGUMENT

The Affordable Care Act's expansion of the Medicaid program is a constitutional exercise of Congress's Article I authority. Petitioners' challenge to the Act's Medicaid expansion lacks any support in this Court's precedents, invites standardless decisionmaking and intractable problems of administration, and is wrong as a matter of constitutional principle.

1. It is well settled that Congress's spending power includes the power to fix the terms on which it will disburse funds to the States. That power is subject to several general restrictions identified in *South Dakota* v. *Dole*, 483 U.S. 203 (1987), including the obligations to spend funds in pursuit of the general welfare, U.S. Const. Art. I, § 8, Cl. 1, and to make conditions on spending clear and unambiguous. Apart from those restrictions, Congress has broad authority to attach conditions to federal spending in order to further federal policy objectives.

In the Medicaid Act, 42 U.S.C. 1396 *et seq.*, Congress exercised its spending power to create a federal-state cooperative program under which participating States agree to comply with program terms in exchange for the federal government's contribution of a percentage of the costs the State incurs in funding medical assistance. These terms include requirements concerning the categories of needy persons eligible for assistance and the categories of benefits to which they are entitled.

In the Affordable Care Act, Congress filled gaps in existing Medicaid coverage by extending eligibility to additional low-income individuals. Petitioners do not

claim that this amendment of the Medicaid program exceeds any of the general restrictions on Congress's spending power described in *Dole*, and no such claim would be tenable. Congress's specification of the additional category of needy individuals entitled to assistance is an unambiguous, foundational term of the Medicaid program that simply prescribes how federal funds must be spent, and requiring a participating State to comply with that term is a valid condition on the disbursement of federal Medicaid funds.

2. Congress's use of the spending power to extend Medicaid eligibility to a new category of low-income individuals does not violate structural principles of federalism by compelling States to implement a federal program.

a. Petitioners' assertion that the Affordable Care Act worked an unprecedented transformation of the Medicaid program rests on a series of mischaracterizations. From the outset, Congress specifically reserved the right "to alter, amend, or repeal any provision" of the Medicaid Act, 42 U.S.C. 1304, and Congress has many times exercised that reserved authority to extend the Medicaid program to new classes of beneficiaries and new kinds of benefits—and has often required States to accept the expansion as a condition of continued participation in the Medicaid program. In the Affordable Care Act, more than in prior Medicaid expansions, Congress took significant steps to reduce the burdens on the States by initially covering all of the costs of funding medical assistance for individuals made eligible by the expansion, and ultimately providing federal assistance at rates far exceeding usual Medicaid matching rates. The resulting additional cost to the States represents less than a 1% increase over their

baseline spending and will be more than offset by cost reductions resulting from the Affordable Care Act. Moreover, the Act preserves States' flexibility to respond to budgetary demands by, *inter alia*, adjusting their spending on certain coverage that is optional, rather than mandatory, under the Medicaid Act.

b. This Court has recognized that, unlike a directive to the States to enact or implement a federal regulatory program, Congress's decision to condition the receipt of federal funds on compliance with federal policy respects principles of federalism by leaving it to States to decide whether federal policy is "sufficiently contrary to local interests" to justify declining federal money. *New York* v. *United States*, 505 U.S. 144, 168 (1992).

Petitioners do not dispute that they are free, as a matter of law, to turn down federal Medicaid funds if they view program conditions as sufficiently contrary to their interests. They contend, however, that the "sheer size" of federal Medicaid grants means they have no practical ability to turn the money down. On their theory of coercion, the greater the federal government's willingness to contribute funds to defray the costs of covering needy individuals (including costs of optional coverage that States chose to add to their Medicaid programs), the less say Congress has in defining the features of its spending program.

No court has accepted such an argument, and for good reason. However attractive the offer of federal Medicaid funding may be, the decision whether to accept it always belongs to the States, and not the federal government. Petitioners' claim of coercion is nothing more than an argument that the citizens of their States would hold them politically responsible for either the reduction in benefits that would result from opting out

of Medicaid or for the increased taxation needed to fund those benefits entirely at the state level. That argument turns notions of political accountability and state sovereignty upside down, for it rests on the assumption that States lack the capacity or the will to accomplish on their own what their citizens desire, and therefore have a right under the Constitution to have courts dictate the terms on which the federal government provides assistance.

The amount of money at stake, moreover, cannot be thought to be the only relevant consideration for States deciding whether to accept conditional federal funding, and different States will weigh the costs and benefits differently. Courts are ill-equipped to second-guess state officials' judgments about matters of budget, revenue, and policy. And critically, there is no logical stopping point to petitioners' argument. It would call into question not only the extension of Medicaid eligibility in the Affordable Care Act, but also every other requirement for participation in the Medicaid program, not to mention an unspecified number of other federal spending programs whose terms grant recipients may find coercively generous.

c. Petitioners suggest that the Court need not articulate any clear and administrable rule of constitutional law to decide this case in their favor on "coercion" grounds because Congress itself premised the Affordable Care Act on the understanding that the States could not leave Medicaid. That argument rests in large part on the erroneous assertion that Congress thought the extension of Medicaid eligibility was needed to enable low-income individuals to avoid the tax penalty for failure to maintain minimum health coverage that they would otherwise face. But the minimum coverage provi-

sion expressly exempts individuals unable to afford health coverage from the tax penalty that is the only consequence of the failure to maintain minimum coverage.

Petitioners also argue that the Affordable Care Act's coercive nature is evident from Congress's failure to provide a comprehensive fallback for low-income individuals living in States that opt out of Medicaid, demonstrating that Congress expected States would continue to participate. Such an expectation is hardly proof of coercion. All States have participated in Medicaid for decades, and Congress had no reason to anticipate that would change, particularly given that the federal government has assumed nearly all the costs of the eligibility expansion. But Congress's expectations do not, in any event, bear on the constitutional analysis. States remain free to opt out of Medicaid if they so choose, and Congress can then adjust other statutory programs as appropriate.

d. Because the extension of Medicaid eligibility falls well within the bounds of Congress's power to fix the terms on which it will appropriate federal funds, there is no reason for this Court to consider petitioners' passing contention that the remainder of the Affordable Care Act is inseverable from the eligibility extension provision. Moreover, this case provides no occasion to consider the continued viability of countless provisions of the Act that do not affect petitioners, but do affect numerous individuals not before the Court. And in any event, the extension of Medicaid eligibility is an amendment to the Social Security Act, whose severability clause instructs that invalidation of any application of that statute shall not affect the remainder of the statute or its other applications. 42 U.S.C. 1303. Were the eli-

gibility extension provision found to be unconstitutionally coercive, the appropriate remedy would be to enjoin its mandatory application to objecting States, but otherwise to allow the provision to operate as written; it would not be to nullify the Affordable Care Act in its entirety.

ARGUMENT

THE AFFORDABLE CARE ACT'S EXPANSION OF MEDICAID ELIGIBILITY IS A VALID EXERCISE OF CONGRESS'S POWER TO SET THE TERMS ON WHICH IT WILL APPROPRIATE FEDERAL FUNDS FROM THE TREASURY

A. Congress Has Broad Authority Under The Spending Clause And Appropriations Clause To Establish The Criteria For Payment Of Money From The Treasury To Support A Federally Funded Program

1. The Constitution grants Congress the power to "lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. Const. Art. I, § 8, Cl. 1. The Constitution further provides that once the proceeds of taxes and other revenues are deposited in the Treasury, "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." U.S. Const. Art. I, § 9, Cl. 7. A central purpose of this Clause "is to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good." *OPM* v. *Richmond*, 496 U.S. 414, 428 (1990).

Consistent with these fundamental principles governing the appropriation of funds in the Treasury, it has long been settled that Congress's spending power includes the power to "fix the terms on which it shall disburse federal money to the States." *Pennhurst State*

Sch. & Hosp. v. *Halderman*, 451 U.S. 1, 17 (1981); accord, *e.g.*, *Massachusetts* v. *United States*, 435 U.S. 444, 461 (1978); *King* v. *Smith*, 392 U.S. 309, 333 n.34 (1968); *Oklahoma* v. *United States Civil Serv. Comm'n*, 330 U.S. 127, 143 (1947). As this Court has long recognized, "[f]unds in the Treasury as a result of taxation may be expended only through appropriation," *United States* v. *Butler*, 297 U.S. 1, 65 (1936) (citing Art. I, § 9, Cl. 7), and it is "the duty of all courts to observe the conditions defined by Congress for charging the public treasury." *Federal Crop Ins. Corp.* v. *Merrill*, 332 U.S. 380, 385 (1947); see *OPM* v. *Richmond*, 496 U.S. at 424-425.

This Court has further recognized that "Congress may, in the exercise of its spending power, condition its grant of funds to the States upon their taking certain actions that Congress could not require them to take." *College Sav. Bank* v. *Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686 (1999). Although Congress may not compel States to implement federal regulatory programs, *New York* v. *United States*, 505 U.S. 144, 166 (1992); *Printz* v. *United States*, 521 U.S. 898, 925 (1997), this Court has made clear that Congress may validly condition a grant of funds on a State's agreement to implement programs consistent with the policy embodied in the Acts of Congress providing for the payment of the relevant funds from the Treasury, *New York*, 505 U.S. at 166-167.

Congress's power to condition the grant of federal funds "is of course not unlimited, but is instead subject to several general restrictions." *South Dakota* v. *Dole*, 483 U.S. 203, 207 (1987) (citation omitted). First, consistent with the text of the Spending Clause, "the exercise of the spending power must be in pursuit of 'the general welfare.'" *Ibid.* Second, conditions under programs for

grants to the States must be unambiguous, "enabl[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Pennhurst*, 451 U.S. at 17. Third, the Court has "suggested (without significant elaboration) that conditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national projects or programs,'" *Dole*, 483 U.S. at 207 (citation omitted). Finally, the Court has "noted that other constitutional provisions may provide an independent bar to the conditional grant of federal funds," *id.* at 208 (citations omitted), such that Congress may "not 'induce' the recipient 'to engage in activities that would themselves be unconstitutional,'" *United States* v. *American Library Ass'n, Inc.*, 539 U.S. 194, 203 (2003) (plurality opinion) (quoting *Dole*, 483 U.S. at 210).

These restrictions ensure that the spending power does not "render academic the Constitution's other grants and limits of federal authority." *New York*, 505 U.S. at 167. Beyond these limitations, however, "Congress has wide latitude to attach conditions to the receipt of federal assistance in order to further its policy objectives." *American Library Ass'n*, 539 U.S. at 203 (plurality opinion).

2. Medicaid is a joint federal-state cooperative program enacted pursuant to Congress's Spending Clause authority. Under the program, "the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons." *Harris* v. *McRae*, 448 U.S. 297, 308 (1980). As this Court has repeatedly recognized, "State participation [in Medicaid] is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements." *Frew* v. *Hawkins*, 540

U.S. 431, 433 (2004); see also *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 275 (2006) (in exchange for federal funds, "the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program"); *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990) ("Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services."); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981) ("State Medicaid plans must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services.").

Since the program began in 1965, the conditions for participation have included agreement by the States to make medical assistance available to specified categories of needy individuals. Since then, Congress many times has required States to cover new categories of individuals, including infants, children, pregnant women, and the disabled. A State's willingness to accept an expanded eligibility requirement has been a condition of continued participation in the Medicaid program itself, and not merely a condition of receiving incremental funding. See pp. 5-7, *supra*.

3. In the Affordable Care Act, Congress addressed existing gaps in Medicaid coverage by extending eligibility to individuals under age 65, not receiving Medicare, and earning less than 133% of the federal poverty level. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII). The result will be to make coverage available to millions of low-income individuals who might otherwise lack access to adequate health care or consume health care services in the form

of uncompensated care. See Gov't Minimum Coverage Br. 7-8.

Petitioners do not claim that the extension of Medicaid eligibility to these low-income individuals exceeds any of the "general restrictions" on Congress's spending power identified in *Dole*, 483 U.S. at 207-208, and no such claim would be tenable. As has been true of prior Medicaid expansions, this extension of Medicaid eligibility promotes the general welfare by increasing access to health care for needy persons. It does so in terms that are unambiguous and that directly advance the overall purpose of the Medicaid program. *Ibid.* Like the Medicaid Act's other specifications about the categories of needy individuals entitled to receive assistance and the categories of services they are entitled to receive, the extension of Medicaid eligibility in the Affordable Care Act is a valid condition on a State's participation in and receipt of federal funds under the Medicaid program.

Indeed, the additional eligibility standards in the Affordable Care Act, like the prior standards, are not mere conditions, designed to further a goal related to the Medicaid program (although, as *Dole*, 483 U.S. at 207, and *New York*, 505 U.S. at 166-167, make clear, Congress may impose such conditions). The eligibility standards *define* the Medicaid program, going to the very core of the offer of federal financial assistance that Congress has extended to the States and specifying how the federal dollars will be spent. For the same reasons, the new eligibility standards in the Affordable Care Act, like pre-existing standards, also go to the very core of Congress's power under the Spending Clause and the Appropriations Clause to specify the criteria under which funds in the Treasury will be paid out and spent. Congress is choosing to act in conjunction with the

States, and prescribing the terms on which federal money will be spent, in an area in which Congress has Article I authority to act directly by establishing and funding a federal program (as it has done, for example, with the Medicare program, see 42 U.S.C. 1395 *et seq.*). In doing so, Congress has acted well within constitutional bounds.[10]

B. The Nature Of the Medicaid Program And The Amount Of The Federal Funding Provided Under It Do Not Extinguish Congress's Authority To Set The Terms On Which It Will Appropriate Money In The Treasury

Petitioners contend (Br. 32-53) that, in enacting the Affordable Care Act, Congress violated structural principles of federalism by "[f]orc[ing]" States to accept Congress's decision to expand Medicaid eligibility. *Id.* at 33. Petitioners do not dispute that, as a matter of federal law, a State remains free to withdraw from the Medicaid program if it does not wish to accept federal funds on the terms under which they are offered. See Pet. App. 283a-284a. But petitioners contend that the "sheer size" of federal Medicaid grants makes it impractical to turn the money down rather than agree to the expanded coverage. States' Br. 23; *id.* at 39-48.

As explained below, petitioners greatly exaggerate the burden on the States resulting from the extension of Medicaid eligibility to additional populations—especially in the context of the Medicaid program as a whole,

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[10] Even Justice O'Connor's dissenting opinion in *Dole*, which would have held the 21-year-old drinking-age condition on federal highway funds unconstitutional on the ground that it was not sufficiently related to the purpose for which the funds were granted to the States, recognized that Congress has full power to specify how federal funds will be spent. 483 U.S. at 216.

and the federal government's assumption of the great majority of the incremental costs. And the savings to the States under the Affordable Care Act are expected to more than offset the increase in expenditures from the extension of Medicaid eligibility. Even more to the point, no decision of this Court—nor, indeed, of any other court—supports petitioners' contention that a State's reluctance to turn down federal Medicaid funds entitles it to ignore the Medicaid program's basic eligibility standards, which define the very core of the program, and to insist that money from the Treasury be appropriated to it on the terms the State would prefer rather than the terms Congress has prescribed.

1. The extension of Medicaid eligibility in the Affordable Care Act is neither unprecedented nor likely to impose significantly onerous burdens on the States

As an initial matter, it is necessary to put petitioners' objections to the extension of Medicaid eligibility into perspective, for a claim that a federal spending program is coercive, even if viable in theory, must be considered in context. Although petitioners depict the extension of Medicaid eligibility in the Affordable Care Act as a "transformative" development in the history of Medicaid, *e.g.*, States' Br. 7, 40, petitioners acknowledge that the Medicaid Act always has mandated coverage for various categories of individuals and benefits, and that Congress has expanded these mandatory categories over time—requiring States to choose whether to accept the expanded obligations or to withdraw from the Medicaid program. See, *e.g.*, *id.* at 5 ("By the end of the decade [*i.e.*, 1989], Congress mandated coverage for all pregnant women, children age 5 and under with family incomes below 133% of the federal poverty level, and

children between the ages of 6 and 18 with family incomes below the federal poverty level.") (citations omitted); *id.* at 5-6 ("Congress periodically increased eligibility thresholds for certain categories of needy.").

In fact, more than in prior Medicaid expansions, Congress took steps in the Affordable Care Act to reduce the burden on the States. The federal government will initially pay 100% of the costs associated with providing medical assistance to individuals covered under the eligibility expansion. 42 U.S.C. 1396d(y). Over the remainder of the decade, that amount will gradually decrease to and then remain indefinitely at 90%—a rate still far greater than the usual federal contribution rates. See 42 U.S.C. 1396d(b) (prescribing federal contribution rates between 50% and 83%); p. 9, *supra* (federal contribution rates have generally averaged 57%).

As petitioners note, CBO has projected that state Medicaid spending will increase by $20 billion between 2010 and 2019 beyond what it would have been over that decade without the Affordable Care Act. But that amount is dwarfed by the projected increase in federal spending of $434 billion. See States' Br. 10 (citing CBO Letter, Tbl. 4 & n.c). Moreover, that amount represents less than a 1% increase over baseline state Medicaid spending (*i.e.*, projected state Medicaid spending without the Affordable Care Act over the same ten-year period). See p. 10, *supra*.[11] The projected increase in the

[11] As noted above, accepting the upper end of the estimates of increased state spending cited by petitioners (States' Br. 10), that number represents less than a 2% increase over baseline state Medicaid spending. See n.6, *supra*.

Petitioners also cite CBO analyses projecting that Medicaid enrollment will increase by 16 million between 2010 and 2020 as a result of the Affordable Care Act. See States' Br. 9-10 (citing CBO Letter 9).

States' spending is also a mere fraction of current spending for categories of individuals and benefits whose coverage is optional, rather than mandatory, under the Medicaid Act. In 2007 alone, for example, combined federal and state spending on enrollees covered at state option totaled $129 billion, and combined spending on services covered at state option for both mandatory and optional enrollees totaled $103.4 billion. *Medicaid Enrollment and Expenditures* 2.

The projected increase in state spending will, moreover, be offset by reductions in other state costs resulting from implementation of the Affordable Care Act, including, among other things, reductions in state costs for uncompensated care. As pointed out above (see p. 11 & n.7, *supra*), several studies have projected that aggregate state spending over the course of the decade will be approximately $100 billion *lower* under the Affordable Care Act than it would have been under prior law.

That estimate, notably, includes both individuals who will become newly eligible for Medicaid as a result of the expansion and millions of individuals who are *already* eligible under existing Medicaid standards, but who have not yet enrolled. See *id.* at 9-10 (citing CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010)). Petitioners are in no position to complain about the new enrollees in the latter category. States participating in Medicaid have agreed to ensure that "all individuals wishing to make application for medical assistance under the [State's Medicaid] plan shall have opportunity to do so." 42 U.S.C. 1396a(a)(8); see, *e.g.*, Florida Agency for Health Care Admin., *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Centers for Medicare and Medicaid Services* 17 (July 1, 2010) (lead petitioner Florida's representation to the federal government that Florida "has a strong historical commitment to Medicaid outreach" and that it has taken a number of steps to encourage eligible individuals to enroll in the program).

Within the Medicaid program itself, the Act fully maintains States' flexibility to reduce costs, whether through the design of the service delivery systems they rely on or through the rates they pay for care provided. See *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985). The Act offers States flexibility to design benefit packages for newly eligible individuals. See 42 U.S.C. 1396a(k)(1), 1396u-7(b) (describing "benchmark" and "benchmark-equivalent" coverage options). And the Act preserves flexibility for the States to choose whether to provide coverage for optional categories of beneficiaries and whether to offer optional benefits to both mandatory and optional beneficiaries.

Every State has elected to provide some optional coverage, which currently accounts for about 60% of total Medicaid spending. *Medicaid Enrollment and Expenditures* App. B, Tbl. 1, at 17 (summarizing spending on mandatory benefits for optional beneficiaries and optional benefits for all beneficiaries).[12] Many States, for example, have elected to extend Medicaid coverage to some "medically needy" individuals, *i.e.*, individuals whose incomes are too high or resources too great to qualify for coverage under Medicaid's mandatory eligibility categories, but who may qualify for optional coverage if their medical expenses are subtracted from their income. See 42 U.S.C. 1396a(a)(10)(C); *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 651 & n.5 (2003); Kaiser Family Foundation, *Income Eligibility Requirements Including Income Limits and Asset Limits for the Medically Needy in Medicaid* (2009). A

[12] See also *Budget Outlook* 39 (same percentage in 2001) (citing Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* 11 (June 2005)).

State may choose to exercise the ability to cover medically needy individuals to fund, for example, nursing-home care for elderly individuals the State is not required to cover. In 2007, the elderly accounted for 44% of all spending on optional enrollees, and long-term care services accounted for 57% of spending for all optional enrollees. See *Medicaid Enrollment and Expenditures* Fig. 3, at 2. As a general rule, a State enjoys considerable flexibility to reduce optional spending if it determines that its fiscal circumstances require it.

The maintenance-of-effort provision noted by petitioners (Br. 8-9) does require States on an interim basis to maintain their current "eligibility standards, methodologies, or procedures." 42 U.S.C. 1396a(a)(74), 1396a(gg). But that requirement will expire with respect to adults when the new health insurance exchanges to be established pursuant to the Affordable Care Act are operational in 2014, and with respect to children in 2019. 42 U.S.C. 1396a(gg)(1) and (2). In the meantime, a State that submits a certification to the Secretary that it has, or is projected to have, a budget deficit is exempt from the requirement with respect to adults with incomes above 133% of the federal poverty level who are not pregnant or disabled. 42 U.S.C. 1396a(gg)(3). And even while it remains in effect, the maintenance-of-effort provision does not impair a State's ability to adjust provider payment rates or drug pricing, or to redesign delivery systems to provide care more efficiently, nor does it prevent a State from reducing spending on optional *services* for individuals covered by the state plan. Thus, States retain flexibility to off-

set increased obligations even during the period up to 2014.[13]

2. *A State's reluctance to turn down federal Medicaid funding does not authorize it to disregard the terms and conditions of the Medicaid program*

Petitioners contend (Br. 39-42) that the Affordable Care Act's changes to the Medicaid program represent an "extreme and unprecedented abuse" of power, *id.* at 23, because failure to comply jeopardizes a State's continued ability to receive federal Medicaid funds. That argument runs headlong into the fundamental principle, repeatedly recognized by this Court, that a State that accepts federal Medicaid funds must agree to administer a state plan that meets the federal standards on which Congress has conditioned its offer of funding assistance. See, *e.g.*, *Harris*, 448 U.S. at 308. Petitioners' contention that a State's reluctance to turn down federal Medicaid grants entitles it to disregard the program's basic terms and conditions finds no support in this Court's cases, has no logical stopping point, and misconceives fundamental constitutional principles.

a. In recognizing Congress's authority to attach conditions to the appropriation of money from the Treasury, this Court has explained that the exercise of that

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[13] Petitioners note in passing that Section 2304 of the Affordable Care Act amended the Medicaid Act's definition of "medical assistance" to include "care and services themselves." See States' Br. 9. Petitioners have previously taken the view that the contours of this amendment are "unclear," that they "cannot be assessed until regulations are promulgated," and that the provision is "thus not amenable to cost projections." Mem. in Support of Pls. Mot. for Summ. J. 42 n.42 (Docket entry No. 80). In any event, legislative history indicates that the provision was intended to clarify, rather than change, existing law. See H.R. Rep. No. 299, 111th Cong., 1st Sess. Pt. 1, 649-650 (2009).

authority, unlike a directive to the States to enact or implement a federal regulatory program, leaves to "the residents of the State" the "ultimate decision as to whether or not the State will comply. *New York*, 505 U.S. at 166-167. If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant." *Id.* at 168.

In nonetheless arguing that the conditions Congress has attached to federal Medicaid funds are unconstitutionally coercive, petitioners rely on this Court's observation in *Dole* that prior "decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" 483 U.S. at 211 (quoting *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 589-590 (1937)); see States' Br. 27. But in rejecting the State's coercion challenge to a condition of a federal highway grant in that case, the Court observed that every financial incentive "is in some measure a temptation," and that "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 589-590). In *Steward Machine* itself, the Court rejected an argument that the federal government had deployed "the whip of economic pressure" to coerce States into enacting unemployment compensation laws. 301 U.S. at 587. Expressing doubt as to whether the concept of "undue influence" "can ever be applied with fitness to the relations between state and nation," the Court explained that the law "has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis." *Id.* at 589-590.

Applying these principles, the courts of appeals have uniformly rejected arguments that conditions on participation in Medicaid and other spending programs are unconstitutionally "coercive" because a State may be reluctant to turn down federal funding. See, *e.g.*, *Van Wyhe* v. *Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (federal grant for state prisons), cert. denied, 130 S. Ct. 3323 (2010); *Jim C.* v. *United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (en banc) (federal education grant), cert. denied, 533 U.S. 949 (2001); *Kansas* v. *United States*, 214 F.3d 1196, 1203-1204 (10th Cir.) (federal welfare grant), cert. denied, 531 U.S. 1035 (2000); *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir.) (Medicaid grant), cert. denied, 522 U.S. 806 (1997); *Padavan* v. *United States*, 82 F.3d 23, 28-29 (2d Cir. 1996) (Medicaid grant); *Nevada* v. *Skinner*, 884 F.2d 445, 448-449 (9th Cir. 1989) (federal highway grant), cert. denied, 493 U.S. 1070 (1990); *Oklahoma* v. *Schweiker*, 655 F.2d 401, 413-414 (D.C. Cir. 1981) (Medicaid grant) (*Schweiker*).[14]

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[14] The Fourth Circuit's decision in *Madison* v. *Virginia*, 474 F.3d 118, 128 (2006), on which petitioners rely (Br. 46, 58), did not depart from these principles. The court of appeals in that case rejected Virginia's challenge to the funding conditions established by the Religious Land Use and Institutionalized Persons Act of 2000, 42 U.S.C. 2000cc *et seq.*, but stated in dictum that "[f]ederal statutes that threaten the loss of an entire block of federal funds upon a relatively minor failing by a state are constitutionally suspect." *Madison*, 474 F.3d at 128 (quoting *West Va.* v. *United States Dep't of Health & Human Servs.*, 289 F.3d 281, 291 (4th Cir. 2002)). Even accepting the Fourth Circuit's dictum for purposes of argument, it provides no basis to question the conditions established by the Affordable Care Act's amendments to the Medicaid program. Those conditions are not "minor"; they are, as petitioners have acknowledged, "core program requirements." Pet. 26.

As these courts have recognized, the size of a federal grant may make it less likely, as a practical matter, that a State will "view federal policy as sufficiently contrary to local interests" to warrant turning down the federal funds. *New York*, 505 U.S. at 168. But that doesn't mean that the federal government, simply by *offering*, has coerced the State into *accepting*. See, *e.g.*, *Jim C.*, 235 F.3d at 1082 ("Sovereign states are fully competent to make their own choice.").

Moreover, to decide whether any given federal grant was large enough to be impermissibly coercive under petitioners' position, courts would inevitably be thrust into the role of arbiters of conflicting policy judgments related to matters of state budgets and revenues and state assessments of the acceptability of various federal conditions. See *Schweiker*, 655 F.2d at 414 (courts "are not suited to evaluating whether the states are faced * * * with an offer they cannot refuse or merely a hard choice"); *Skinner*, 884 F.2d at 448 ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments.").

In this case, for example, although petitioners ask the Court to invalidate the Affordable Care Act's amendments to Medicaid as impermissibly coercive, other state officials have defended the "Medicaid expansion as an affordable and preferable alternative to the costs that their states would have faced, without any federal assistance, to underwrite health insurance for poor, childless adults or to subsidize uninsured care for such

populations."[15] A number of States in fact have already chosen to extend eligibility to the additional populations made eligible by the Affordable Care Act, even before the effective date for mandatory coverage and before the increased contribution rate is available.[16] Petitioners offer no metric by which a court could resolve the apparent disagreements among state officials about any assertedly "coercive" effect of a federal funding program without delving into essentially political questions about States' differing policy choices and budgetary priorities.

Nor would it enhance the autonomy and sovereignty of the States within our federal system over the long term to subject such matters to judicial determination by federal courts, rather than the politically accountable officials of the States and the United States. Quite the opposite. It is a central principle of our system of dual sovereignty that the United States and the States will exercise independent judgment concerning what spending measures will best promote the public welfare within their respective spheres. As part of that responsibility, each must decide for itself whether promotion of the general welfare would be best achieved by independent action, or instead by entering into a cooperative financial arrangement with the other. The Medicaid Act, since its inception and as amended by the Affordable Care Act, sets forth the terms and conditions under

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[15] Governors Amicus Br. 13 (Docket entry No. 133); see also Amicus Br. of Oregon, Iowa, Vermont, Maryland, and Kentucky, supporting Def. Mot. for Summ. J. (Docket entry No. 130); Amicus Br. of State Legislators, supporting Def. Mot. for Summ. J. (Docket entry No. 126).

[16] California, for example, has obtained a waiver allowing it to begin covering individuals with income at or below 133% of the poverty line in advance of 2014. See California et al. Severability Amicus Br. 16.

which Congress has offered to enter into such an arrangement and to furnish funds from the Treasury to assume what Congress has determined to be its fair share of the cost of providing needed medical care to low-income people in the States.

Petitioners' arguments are impossible to square with these fundamental postulates. At bottom, what petitioners are contending is that it would be politically untenable for them to withdraw from Medicaid because their citizens would bridle at the resulting loss of medical services or the added tax burden needed to maintain these services. What petitioners describe as coercion is merely a reflection of the policy preferences of their own citizens. And what they seek is the ability to use the courts to tailor federal spending programs to their preferred specifications, and thereby avoid political accountability for the consequences that would follow from rejecting federal aid on the terms offered.

No principle of federalism confers on the States such unilateral authority to dictate the conditions under which funds appropriated by Congress will be spent, or to pick and choose among those conditions. To the contrary, the Spending Clause, the Appropriations Clause, and the Supremacy Clause foreclose recognition of such authority in the States. This Court has observed that cooperative federal-state programs enacted pursuant to the Spending Clause are "in the nature of a contract" between the federal government and the State. *Pennhurst*, 451 U.S. at 17; see *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006). Viewing petitioners' claim through that lens, the terms and conditions embodied in the Medicaid Act, both at its inception and as amended by the Affordable Care Act, constitute the offer by the United States to enter into or

maintain a contractual relationship with the States. The States are free to accept or reject that offer, but they have no right to insist that Congress change its offer to make it more acceptable to the States.

b. Petitioners contend (Br. 39-40) that the extension of Medicaid eligibility in the Affordable Care Act is uniquely coercive because of the "unparalleled" size of federal Medicaid grants, and because of the possibility that failure to adhere to the new standards may "put at risk pre-existing funding streams" on which States have come to depend. But the features petitioners describe were not newly introduced by the Affordable Care Act. The Medicaid program has long been the largest federal grant-in-aid program. See *Schweiker*, 655 F.2d at 403. It has long had both mandatory and optional features. And the program has grown as a consequence of the decisions States themselves have made not only to remain in the program over time but also to take advantage of its optional features and the additional federal funds associated with those options. Nothing in that experience supports the conclusion that the extension of Medicaid eligibility in the Affordable Care Act is unconstitutionally coercive.

It would be a perverse result if, having voluntarily sought substantially increased Medicaid funding from the federal government (especially by expanding optional coverage), a State could then turn around and claim that the amount of the funding it has chosen to accept has—by the very fact of that acceptance—become a basis for blocking any change in the terms and conditions on which Congress is prepared to continue furnishing financial assistance. Yet that is precisely what petitioners contend. No principle of Our Federalism requires that a State's participation in a federal

funding program gives rise to a right unilaterally to alter the conditions on which federal funds will be paid out of the Treasury under the program going forward.

Indeed, petitioners' argument cannot be reconciled with this Court's decision in *OPM* v. *Richmond*. There, the Court held that there can be no claim of estoppel, based on asserted misrepresentations by federal employees, to obtain funds from the federal Treasury under a federal benefits program on terms different than those prescribed by Congress in the governing statute. 496 U.S. at 419-424. The Court concluded that any such notion of estoppel would conflict with the exclusive power granted to Congress under the Appropriations Clause. *Id.* at 424-434. Petitioners' argument in this case is at bottom one of estoppel as well—that Congress, having offered a program of federal financial assistance with particular attributes, and the States having accepted, may not alter the basic eligibility standards under that program, but must instead give to the States an option whether to comply with the changed standards. It follows *a fortiori* from *OPM* v. *Richmond* that the Appropriations Clause allows no such principle of estoppel against the United States *as a constitutional matter* that would prevent Congress from altering the contours of the overall program. Indeed here, the asserted estoppel arises from the States' own voluntary action, not from any misleading by Congress. To the contrary, as we shall next explain, Congress could not have been clearer that it reserved the power to revise the program.

c. Petitioners suggest (Br. 37; see *id.* at 6 n.6) that the Congress that enacted the Affordable Care Act should have eliminated any risks to pre-existing funding streams by giving participating States the option to

cover new categories of individuals rather than making their eligibility a mandatory term of Congress's offer of federal financial assistance. But it is not the case, as petitioners seem to suggest (*id.* at 37), that Congress has always given participating States a choice whether to cover new categories of individuals in exchange for additional federal funding. See pp. 5-7, *supra*. More fundamentally, under Medicaid as under other provisions of the Social Security Act, as well as other statutes enacted pursuant to the Spending Clause, it is "inevitable" that "amendment of its provisions would be necessary in response to evolving social and economic conditions." *Bowen* v. *Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 51 (1986). Congress's ability to make changes in any such program "is implicit in the institutional needs of the program." *Id.* at 52 (quoting *Flemming* v. *Nestor*, 363 U.S. 603, 611 (1960)).

In the Social Security Act, Congress has made its reservation of such power explicit, expressly reserving "the right to alter, amend, or repeal any provision" of that statute. 42 U.S.C. 1304. As the Court has explained with respect to this very provision, "the 'effect of these few simple words' has been settled since the *Sinking-Fund Cases*, 99 U.S. [9 Otto] 700 (1879)," *Public Agencies*, 477 U.S. at 53 (citation omitted): through such language, "Congress not only retains, but has given special notice of its intention to retain, full and complete power to make such alterations and amendments as come within the just scope of legislative power," *Sinking-Fund Cases*, 99 U.S. [9 Otto] at 720. Without defining "the limits of the reserved power," the Court in *Public Agencies* and the *Sinking-Fund Cases* thought it "'safe to say' that Congress had the authority

to provide by amendment whatever rules it might 'have prescribed'" in its initial enactment. *Public Agencies*, 477 U.S. at 54 (quoting *Sinking-Fund Cases*, 99 U.S. at 721). Petitioners do not appear to dispute that Congress could have included in its initial enactment of the Medicaid Act the entire set of terms and conditions that will be in effect in 2014 following the amendments made by the Affordable Care Act. It therefore is "safe to say" that, by virtue of 42 U.S.C. 1304, Congress "had the authority to provide by amendment," *Public Agencies*, 477 U.S. at 54, the additional category of beneficiaries made eligible by the Affordable Care Act.

Petitioners acknowledge that they entered into the Medicaid program knowing they had no "vested right that the program would continue indefinitely or upon the same terms." States' Br. 41. Having done so, under statutory terms that have long been understood to reserve to Congress an authority to alter that is as broad as its power to enact, petitioners can claim no entitlement to continue participating in Medicaid and receiving federal Medicaid funds on "unaltered" terms. *Id.* at 42.

What is more, the Medicaid Act has always authorized the Secretary to withhold federal funding for noncompliance. Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121(a), § 1904, 79 Stat. 351 (now codified at 42 U.S.C. 1396c). That authorization has always included the discretion to withhold either part or all of the entire federal grant. *Ibid.* (if the Secretary determines that a State has failed to comply with the terms of the program, the Secretary shall notify the State "that further payments will not be made to the State (*or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure*), until the Secretary is satisfied that there will

no longer be any such failure to comply") (emphasis added); see Pet. App. 62a; cf. States' Br. 35 n.15, 37, 39-40. As a practical matter, the Secretary's withholding power remains largely untested: The federal government and the States alike have every incentive to resolve compliance issues to ensure that needy individuals continue to receive needed medical assistance, and petitioners identify no instance in which a participating State's Medicaid funding has been terminated for noncompliance. But the Secretary's power to insist on compliance is not new.

d. Petitioners' focus on the size of federal Medicaid grants also ignores other factors relevant to a State's decision to accept or reject federal funding. In petitioner's view, because "[c]oercion is measured by how much a State stands to lose if it *rejects* Congress' terms" in its offer of federal financial assistance, States' Br. 46, it is immaterial that Congress has taken on the lion's share of the cost of funding medical assistance for the additional category of needy state residents. In petitioners' view, the generous terms of the federal government's offer can only make the offer *more* coercive: "If the ACA offered States double the amount of their Medicaid expenditures if they would accept the new conditions, that double or nothing offer * * * would make the offer harder, not easier, to refuse, and would render any notion of meaningful choice that much more illusory." *Id.* at 47. On petitioners' through-the-looking-glass theory, the better the bargain for the State, the more reason to conclude that the State has been impermissibly "coerced" into accepting it. Presumably, the Act's Medicaid eligibility expansion would have been even more coercive Congress chosen to fund indefinitely 100% of all its costs. That cannot possibly be the law.

And petitioners offer no guidance for determining when States have become sufficiently helpless in their dependency that they can no longer exercise their autonomy as sovereigns to decline participation in a federal program.

In any event, this is not a case in which the federal government has offered a State substantial sums that are unrelated to or far in excess of the costs of the federally funded program in order to induce the State to take particular action—particularly action that is only marginally related to the federal purpose. Here, Congress has chosen to fund a greater proportion (but still less than 100%) of the costs of the very program that the federal government has offered to support. It would be an exceedingly odd notion that, in a program like Medicaid, which is in the nature of a contract, one party (the State) would have a cognizable claim that the other party (the United States) is offering *too much* consideration for the former's acceptance and performance of the contract.

e. Petitioners suggest that conditions on the receipt of Medicaid funding are constitutionally suspect because the federal government's revenues are drawn from States' "own taxpayers." States' Br. 44. They thus argue that "[t]he choice given States is the equivalent of that offered by a pickpocket who takes a wallet and gives the true owner the 'option' of agreeing to certain conditions to get the wallet back or having it given to a stranger." *Ibid*.

Invocation of that unfortunate analogy does a serious disservice to the worthy undertaking by Congress and the States (including the petitioner States themselves) over time to furnish needed health care to those who cannot afford it. More fundamentally, however, it rests

on a serious misconception of our Constitution's structure. Federal taxpayers are not merely citizens of the States; they "are also citizens of the United States." *Massachusetts* v. *Mellon*, 262 U.S. 447, 485 (1923). Under Article I, Section 8 of the Constitution and the Sixteenth Amendment, Congress taxes the citizens of the United States directly. Cf. *New York*, 505 U.S. at 165 (explaining that, under our constitutional framework, Congress "exercise[s] its legislative authority directly over individuals rather than over States").[17]

The people in a State are the State's "own taxpayers" when the State itself taxes the people. The national government does not depend for its support on either the States themselves or a share of the revenues that citizens of the States pay to the States in taxes. And the independent authority of the States to tax and spend in no way detracts from the power of Congress to levy *federal* taxes and to appropriate money in the *federal* Treasury. As is true under the Commerce Clause, Congress's power to levy taxes and spend for the general welfare "can neither be enlarged nor diminished by the exercise or non-exercise of state power." *Gonzales* v. *Raich*, 545 U.S. 1, 29 (2005) (quoting *United States* v. *Darby*, 312 U.S. 100, 114 (1941)). Petitioners' contrary

[17] Petitioners' professed concern for state taxpayers is hard to square with their request that this Court invalidate hundreds of billions of dollars of federal premium tax credits authorized by the Affordable Care Act. See States' Br. 54 n.18 (arguing that the Court should invalidate the Affordable Care Act in its entirety if it concludes that the Medicaid eligibility expansion is unconstitutional); States' Severability Br. 42-59; see also *CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 14, Tbl. 2 (Mar. 18, 2011) (estimating that, between 2012 and 2021, premium tax credits and related spending will cost the federal government $777 billion).

view would cast doubt on every conditional federal grant, allowing a State, in every case, to claim that it was impermissibly coerced into accepting federal funds to avoid having federal tax dollars diverted to "stranger[s]."

There is similarly no merit to petitioners' contention (Br. 50-52) that the federal government acts coercively if it uses money collected through taxation to fund a spending program without dedicating "equivalent funds" to States that have opted out of the program.[18]

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[18] Petitioners point to what they characterize as the "staggering $110 billion" collected from Florida residents by the federal government in 2009. States' Br. 44. Putting aside the fact that the figure represents gross collections (after refunds it was approximately $85 billion, IRS, *Data Book, 2009*, Tbl.5, at 12 (listing gross collections), Tbl. 8, at 19 (listing refunds) (2010)), petitioners fail to mention that, according to U.S. Census data, Florida was the recipient of approximately $181 billion in federal revenues that year. U.S. Census Bureau, *Consolidated Federal Funds Report for Fiscal Year 2010*, Tbl. 13, at 26 (2011) (providing historical spending data by State). Thus, had Florida withdrawn from Medicaid in 2009, the fiscal consequence would have been that the net subsidy its residents received from taxpayers in other States of the Union would have been somewhat less. To be sure, 2009 was an unusual year because of the severe economic downturn. But a comparison of federal expenditures and federal tax collections from 1981 to 2005 reveals that Florida more often than not received more revenue than it paid in federal taxes. The Tax Foundation, *Federal Taxes Paid vs. Federal Spending Received by State, 1981-2005* (2007). Most of the petitioner States likewise received more in revenue than they paid in federal taxes in most years during that span. *Ibid.* Even more importantly, these figures illustrate the implausibility of measuring "coercion" by comparing what residents of a State pay in federal taxes and the federal revenues the State receives. On petitioners' logic, States such as Texas or California, whose residents typically pay more in federal taxes than the States receive in federal revenues, see *ibid.*, could claim "coercion" every time Congress included a new condition on a federal spending measure.

Certainly *Steward Machine*, on which petitioners rely (*ibid.*), stands for no such principle. In *Steward Machine*, Congress had enacted the federal unemployment tax in order to encourage States "to contribute [their] fair share to the solution" of a national employment crisis that had imposed a "disproportionate" and "mountainous" burden on the federal government in furnishing relief to the people affected. 301 U.S. at 588. The Court explained that the unemployment provisions of the Social Security Act were "an attempt to find a method by which all these public agencies may work together to a common end." *Ibid.* The Court further observed that "[e]very dollar of the new taxes will continue in all likelihood to be used and needed by the nation as long as states are unwilling, whether through timidity or for other motives, to do what can be done at home." *Id.* at 588-589. "At least," the Court continued, "the inference is permissible that Congress so believed, *though retaining undiminished freedom to spend the money as it pleased*." *Id.* at 589 (emphasis added).

As the emphasized language demonstrates, nothing in *Steward Machine* suggests that a particular State has the right to demand that the Congress of the United States appropriate federal funds derived from federal taxes for the benefit of the State's residents, regardless of whether the State agrees to comply with conditions attached to the appropriation made to address a national problem. To the contrary, in a decision issued on the same day as *Steward Machine*, the Court made clear that it "is not a valid objection" to a tax "that those who pay the tax * * * may not be benefited by the expenditure." *Carmichael* v. *Southern Coal & Coke Co.*, 301 U.S. 495, 521 (1937); see *id.* at 522 (a tax is not an "assessment of benefits," but "a means of distributing

the burden of the cost of government"); accord *Commonwealth Edison Co.* v. *Montana*, 453 U.S. 609, 622-623 (1981) (quoting *Carmichael*).

f. Although petitioners purport to mount a challenge limited to the extension of Medicaid eligibility in the Affordable Care Act, States' Br. 53-59, the logic of their arguments would appear to apply to the categories of eligible individuals and benefits Congress has required to be covered in the past. Petitioners do not explain whether longstanding Medicaid requirements, like the requirement to cover poor children, *e.g.*, 42 U.S.C. 1396a(10)(A)(i)(VI), or to cover inpatient hospital services, 42 U.S.C. 1396d(a)(1), or to comply with federal civil rights laws, *e.g.*, 42 C.F.R. Pt. 80, have been coercive all along or have become coercive over time as Medicaid spending has grown.

Nor are the implications of petitioners' theory limited to Medicaid. Petitioner Florida, for instance, in 2008 received $728 million under Title I of the Elementary and Secondary Education Act of 1965, 20 U.S.C. 6301 *et seq.*, as amended by the No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425, a program whose purpose is to improve the achievement of low-achieving students who attend high-poverty schools.[19] Congress has conditioned a state educational agency's receipt of Title I funding on the agency's compliance with federal requirements designed to further this purpose. See 20 U.S.C. 6301 *et seq.*; see also *Horne* v. *Flores*, 129 S. Ct. 2579, 2601 (2009). In addition, state education programs that accept federal funds must comply with the requirements established by federal stat-

[19] See Department of Education, *State Funding History Tables By State*, http://www2.ed.gov/about/overview/budget/history/sthistbyst01to08.pdf.

utes such as Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Family Educational Rights and Privacy Act of 1974.[20] Petitioners observe that federal Medicaid grants are generally larger than other federal grants, States' Br. 56, but offer no principled basis for deciding whether other grants, too, might be large enough that the Constitution would require invalidation of the conditions Congress has attached to them.

g. Finally, the basic flaws in petitioners' position are underscored by considering steps Congress unquestionably could take, even under petitioners' view, that are directly parallel to the steps Congress *did* take. First, there can be no doubt that Congress could repeal outright the Medicaid program as it currently exists, despite whatever expectations concerning continuation of the program the States might have. Second, it is clear, and petitioners appear to concede, that Congress constitutionally could have enacted the Medicaid program at the outset in one statute that contained all of the features of the program as it will exist when the amendments made by the Affordable Care Act become effective in 2014. Third, there is no reason why Congress could not repeal the Medicaid program entirely and es-

[20] See *Board of Educ. of Westside Cmty. Schs.* v. *Mergens*, 496 U.S. 226, 241 (1990) (noting that because the Equal Access Act "applies only to public secondary schools that receive federal financial assistance, * * * a school district seeking to escape the statute's obligations could simply forgo federal funding. Although we do not doubt that in some cases this may be an unrealistic option, Congress clearly sought to prohibit schools from discriminating on the basis of the content of a student group's speech, and that obligation is the price a federally funded school must pay if it opens its facilities to noncurriculum-related student groups.").

tablish a new program—containing all of these features and taking effect in 2014—for helping to fund the States in furnishing medical assistance to low-income individuals. See *Gray Panthers*, 453 U.S. at 37-38 (discussing the replacement of three welfare benefits programs with SSI). And fourth, if Congress had repealed Medicaid and established such a new program to take effect in 2014, Congress could have provided a transitional program for the interim period to provide for some continuation of benefits. In substance, this is what Congress did in the Affordable Care Act, albeit by amending the Medicaid Act rather than repealing it and enacting a new program to take effect four years later, with a transitional program in the interim. If each of the separate measures described above would be constitutional, as it surely would be, there is nothing to render them unconstitutional when considered together and as changes to an existing program.

3. There is no merit to petitioners' contention that various provisions of the Affordable Care Act reflect an acknowledgment by Congress that the Medicaid eligibility extension is impermissibly coercive

Petitioners acknowledge, with considerable understatement, that their suggested "line between coercion and persuasion may not be bright." States' Br. 30. But they argue that whatever difficulties the Court may encounter in other cases, the Affordable Care Act crosses that line because Congress itself expected the States to remain in the Medicaid program, as evidenced by its decision to "t[ie] Medicaid to the individual mandate" and its failure to provide a fallback option in case States opted out. *Id.* at 33; see *id.* at 33-39. Petitioners' characterization of the Affordable Care Act is incorrect, and

petitioners' reliance on their assessment of Congress's expectations is in any event misconceived.

a. Petitioners err in asserting that the extension of Medicaid eligibility was designed to provide a means of supplying health insurance coverage to low-income individuals "forced to obtain coverage by the [Affordable Care Act] and its individual mandate." States' Br. 34-35. The minimum coverage provision does not "force[]" low-income individuals to obtain health insurance coverage. Indeed, the provision does not "force[]" *anyone* to obtain coverage. It instead provides that, beginning in 2014, applicable individuals who fail to maintain a minimum level of health coverage for themselves or their dependents will owe a tax penalty for each month in the tax year during which minimum coverage is not maintained. 26 U.S.C. 5000A; see Gov't Minimum Coverage Br. 59-62.

Moreover, individuals who are not required to file a federal income tax return for a given year are exempt from the penalty. 26 U.S.C. 5000A(e)(2).[21] Congress also exempted individuals whose premium payments would exceed 8% of their household income, 26 U.S.C. 5000A(e)(1) (exemption for "Individuals who cannot afford coverage"),[22] and Congress authorized the Secre-

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[21] As noted above, note 8, *supra*, generally, for 2011, the threshold for filing an income tax return is $9500 in gross income for a single taxpayer under the age of 65; $12,200 for a head of household under 65; and $19,000 for a married couple under 65 filing jointly.

[22] As noted above, note 5, *supra*, except in Alaska and Hawaii, the federal poverty level in 2010 was $10,830 for one person. Based on that figure, 8% of the income of an individual at the upper end of the range covered by the Affordable Care Act's extension of Medicaid eligibility (133% of the federal poverty level, plus a 5% income disregard, see *ibid.*) would be $1195.

tary of HHS to exempt other individuals who are determined by the Secretary "to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan," 26 U.S.C. 5000A(e)(5). Congress manifestly did not expect low-income individuals to enroll in Medicaid for the purpose of avoiding a minimum coverage penalty from which low-income individuals who cannot afford health insurance would be exempt.

b. Nor is it relevant for constitutional purposes that Congress did not provide a "contingency plan" in the event a State decided to terminate its participation in the Medicaid program. The federal share of the cost of the expanded coverage under the Affordable Care Act's Medicaid amendments is far greater than under the Medicaid program generally, funding at least 90% of the costs of furnishing medical assistance for newly eligible individuals. Congress was aware that all States have participated in Medicaid for decades and that all of the participating States have chosen to provide far more expansive coverage than the Medicaid Act requires. It is therefore unsurprising that Congress anticipated that the States would choose to accept the exceedingly generous federal assistance for the benefit of the States' own residents in need of health care, and therefore did not provide a comprehensive fallback provision for individuals in the event the States in which they resided chose not to participate in Medicaid. By contrast, the Affordable Care Act's provisions for States to establish insurance exchanges if they choose to do so, to which petitioners point (Br. 35), did not build on longstanding, widespread experience among the States. It therefore is equally unsurprising that Congress did provide a fallback mechanism allowing the federal government to

establish an insurance exchange if the State chose not to do so.[23]

Whatever Congress's expectations about States' continued participation in Medicaid might have been, however, States remain free to frustrate those expectations by adopting the "'simple expedient' of not yielding to what [they] urge[] is federal coercion." *Oklahoma* v. *United States Civil Serv. Comm'n*, 330 U.S. at 143-144 (citing *Mellon*, 262 U.S. at 482). If one or more States elect to withdraw from Medicaid, Congress has the authority to adjust other programs accordingly. Congress's perceived expectations have no bearing on the question whether Congress has unconstitutionally coerced the States to participate in Medicaid.

c. Rejecting petitioners' argument does not mean, as petitioners would have it, "abandoning the very framework of our system of constitutional governance." States' Br. 32. To decide this case it suffices to conclude that Congress has not exceeded the structural limitations of our system of dual sovereignty by requiring States that choose to accept Congress's offer of federal financial assistance under the Medicaid program to comply with Congress's specification of the core elements that define the minimum scope of that program, including the category of needy individuals for whom Congress has chosen to make its assistance available. To accept petitioners' argument would, on the other hand, violate our constitutional structure by allowing a State to ignore the terms on which Congress has appropriated public funds from the Treasury in pursuit of the general welfare.

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[23] Cf. States' Br. 35-36 (discussing special rule authorizing federal premium tax credits for certain low-income individuals ineligible for Medicaid because of their alien status).

C. There Is No Basis To Believe That Congress Would Have Wanted The Entire Affordable Care Act To Fall If The Extension Of Medicaid Eligibility In Non-Consenting States Were Invalidated

In a footnote, petitioners assert that, if the extension of mandatory Medicaid eligibility were held unconstitutional, the entire Act should be declared a nullity. States' Br. 54 n.18. Because the Act's provision for the extension of Medicaid eligibility is constitutional, there is no reason to address that argument. The argument is not, in any event, properly presented in this case. The Affordable Care Act is multi-faceted legislation that contains numerous provisions addressing a wide variety of subjects beyond the extension of Medicaid eligibility, the great majority of which have no application to petitioners. This Court should not consider the validity of provisions of the Act that are not directed to petitioners but do affect numerous persons not before the Court. See Gov't Severability Br. 14-25.

Even if petitioners' sweeping severability argument were properly presented, there would be no basis to invalidate more of the Affordable Care Act amendments to the Medicaid Act than necessary to remedy the asserted violation. The severability clause in Chapter VII of Title 42 (which includes the Medicaid Act, 42 U.S.C. 1396 *et seq.*), provides: "If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby." 42 U.S.C. 1303. Should this Court conclude that the "application" of the extension of Medicaid eligibility is unconstitutionally coercive as applied to States that do not want to accept that portion of Congress's offer of federal finan-

cial assistance, the appropriate remedy, as directed by 42 U.S.C. 1303, would be to enjoin the "application" of the provision to unconsenting States and otherwise to permit the eligibility extension to function as written. Cf. *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 331 (2006) (indicating that a similar injunction may have been an appropriate remedy in light of a similarly worded severability provision).[24] There is no basis to believe that Congress would have preferred no Medicaid eligibility extension at all to an eligibility extension that applies only to consenting States. Far less is there any basis to believe that, having enacted the Affordable Care Act against the background rule of severability in the Social Security Act, Congress would have preferred invalidation of the Affordable Care Act in its entirety to relief that was directly tailored to the finding of a constitutional violation in one of the amendments it made to the Social Security Act.

[24] Petitioners concede (Br. 47-48, 50) that the Act's provisions for expansion of Medicaid eligibility to additional populations are constitutional as applied to consenting States.

CONCLUSION

The judgment of the court of appeals upholding the Medicaid eligibility expansion should be affirmed.

Respectfully submitted.

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APPENDIX

1. U.S. Const. Art. I, § 8, Cl. 1 provides, in pertinent part:

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States[.]

2. U.S. Const. Art. I, § 9, Cl. 7 provides:

No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law; and a regular Statement and Account of the Receipts and Expenditures of all public Money shall be published from time to time.

3. 26 U.S.C. 5000A (Supp. IV 2010) provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.—

(1) In general.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more

months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty.—

(1) In general.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide cover-

age for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount.—For purposes of paragraph (1)—

(A) In general.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in.—The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families.—For purposes of this section—

(A) Family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income.—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[**(D) Repealed.** Pub. L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) Applicable individual.—For purposes of this section—

(1) In general.—The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions.—

(A) Religious conscience exemption.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry.—

(i) In general.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.—The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.—No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage.—

(A) In general.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential cover-

age described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) Indexing.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold.—Any applicable individual for any month during

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[1] So in original. Probably should be followed by "the".

a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps.—

(A) In general.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.—For purposes of this section—

(1) In general.—The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans

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[2] So in original. The semicolon probably should be a comma.

Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan.—Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market.—Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.—Coverage under a grandfathered health plan.

(E) Other coverage.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan.—The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.—The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms.—Any term used in this section which is also used in title I of the Pa-

tient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.—

(1) In general.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.—Notwithstanding any other provision of law—

(A) Waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

4. 42 U.S.C. 1303 provides:

Separability

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.

5. 42 U.S.C. 1304 provides:

Reservation of right to amend or repeal

The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.

6. 42 U.S.C. 1396a (2006 & Supp. IV 2010) provides, in pertinent part:

State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I,

X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37),[1] 606(h),[1] or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)[1] of this title),

(II)(aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase "the first day of the month following",

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (*l*)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (*l*)(2)(A) of this section for such a family;[2]

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[1] See References in Text note below.

[2] So in original. The semicolon probably should be a comma.

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (*l*)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(B) of this section for such a family,

(VII) who are described in subparagraph (D) of subsection (*l*)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(C) of this section for such a family;[2] or

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsection (k);[3]

(ii) at the option of the State, to[4] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to[4] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

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[2] So in original. The semicolon probably should be a comma.

[3] So in original. Probably should be followed by "and".

[4] So in original. The word "to" probably should not appear.

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;[2]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the

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[2] So in original. The semicolon probably should be a comma.

State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;[5]

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assis-

[5] So in original. The semicolon probably should be a comma.

tance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;[5]

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);[5]

(X) who are described in subsection (m)(1) of this section;[5]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agree-

ment with the Commissioner of Social Security under section 1382e or 1383c of this title;[5]

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals);[6]

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396*o* of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);[5]

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title;[6]

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;[6]

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[5] So in original. The semicolon probably should be a comma.

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);[6]

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State;[6]

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(XIX) who are disabled children described in subsection (cc)(1);

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);[2]

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);[2] or

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

* * * * *

7. 42 U.S.C. 1396d provides in pertinent part:

Definitions

For purposes of this subchapter—

* * * * *

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to subsections (y), (z), and (aa) and section 1396u-3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this

subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r-4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

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(y) Increased FMAP for medical assistance for newly eligible mandatory individuals

(1) Amount of increase

Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be equal to—

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) Definitions

In this subsection:

(A) Newly eligible

The term "newly eligible" means, with respect to an individual described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u-7(b)(1) of this title or benchmark equivalent coverage described in section 1396u-7(b)(2) of this title that

has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u-7(b)(1) of this title, or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) Full benefits

The term "full benefits" means, with respect to an individual, medical assistance for all services covered under the State plan under this subchapter that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1396a(a)(10)(A)(i) of this title.