Nos. 11-11021 & 11-11067

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees/Cross-Appellants,

v.

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

Defendants-Appellants/Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA

BRIEF *AMICI CURIAE* OF MINNESOTA LEGISLATORS AND NORTH CAROLINA LEGISLATIVE LEADERS IN SUPPORT OF PLAINTIFFS-APPELLEES/CROSS-APPELLANTS

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State of Florida, et al. v. US Department of Health & Human Services, et al.
Nos. 11-11021 & 11-11067

RULE 26.1 CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and 11th Cir. R. 26.1-1, amici make the following disclosure: each amicus joining in this brief is a government official. None has a parent corporation, subsidiary, or affiliate, and none has issued shares or debt securities to the public. As a result, no publicly held company owns 10 percent or more of the stock of any of the amici. Counsel certifies that he believes that the Certificate of Interested Persons filed by Appellees is complete, with the following additions of the *amici curiae* represented in this brief, and their attorneys:

The *Amici Curiae* represented in this brief:

Sen. Philip E. Berger, President Pro Tempore, North Carolina Senate;

Rep. Thom Tillis, Speaker of the North Carolina House of Representatives

Sen. Harry Brown, Majority Leader, North Carolina Senate

Rep. Paul "Skip" Stam, Majority Leader, North Carolina House of Representatives

Rep. Kurt Zellers, Speaker of the Minnesota House of Representatives

Rep. Matt Dean, Majority Leader of the House of Representatives

The following members of the Minnesota House of Representatives:

Rep. Torrey Westrom

Rep. Doug Wardlow

Rep. Steve Drazkowski

Rep. Kelby Woodard

Rep. Pat Mazorol

Rep. Dan Fabian

Rep. Kurt Bills

Rep. Ron Shimanski

Rep. Mary Kiffmeyer

Rep. Larry Howes

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Rep. Joe Hoppe

Rep. Joe Schomacker

Rep. John Kriesel

Rep. Mary Liz Holberg

Rep. Tim O'Driscoll

Rep. Rod Hamilton

Rep. Pat Garofalo

Rep. Bob Gunther

The following members of the Minnesota State Senate:

Sen. Gretchen Hoffman

Sen. Sean Nienow

Sen. Mike Parry

Sen. David Brown

Sen. Roger Chamberlain

Sen. Julianne Ortman

Sen. Michelle Fischbach, President, Minnesota Senate

Sen. Amy Koch, Majority Leader, Minnesota Senate

Sen. Geoff Michel, Deputy Majority Leader, Minnesota Senate

Sen. Scott Newman

Sen. Paul Gazelka

Sen. David Hann

Sen. Warren Limmer

Sen. Dan Hall

Sen. Joe Gimse

Sen. Dave Thompson

Sen. Bill Ingebrigtsen

Sen. Pam Wolf

Sen. Mike Jungbauer

Sen. Ted Daley

Sen. Ray Vandeveer

Sen. Michelle Benson

Sen. Al DeKruif

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/s/Rebekah N. Plowman
Rebekah N. Plowman

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INTEREST OF *AMICI*

As legislators, *amici* have a direct interest in this case arising from their constitutional responsibility to safeguard the budgetary resources of their respective states. The Patient Protection and Affordable Care Act of 2010 ("ACA") fundamentally transforms the Medicaid Program and in so doing, effectively usurps control over the States' budgets and legislative agendas, crowding out spending on other state priorities.[1] Given their constitutionally mandated role in shaping state budgets, the *amici* have a vital stake in ensuring limitations on federal spending powers are maintained.[2]

The parties have consented to the filing of this brief.[3]

STATEMENT OF THE ISSUES

1. Whether the Affordable Care Act's Medicaid mandates on States are so vague, indefinite, and subject to *ad hoc* modification as to violate

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[1] *See, e.g.*, Minnesota Constitution, Article 13, § 1 ("it is the duty of the legislature to establish a general and uniform system of public schools" that is "thorough and efficient"); North Carolina Constitution, Article IX, § 2, Article I, § 15 (similar).

[2] *See* North Carolina Constitution, Article V, § 7, Article I, § 8 (The people of this state shall not be taxed . . . without the consent of themselves or their representatives in the General Assembly, freely given."); Minnesota Constitution, Article XI, § 1.

[3] No party or its counsel authored this brief in whole or in part. No one other than *amici* and their counsel contributed money to fund the preparation or submission of this brief.

the Spending Clause?

2. Whether the ACA's individual mandate is valid under the Commerce Clause, despite the invalidity of the Government's cost-shifting rationale?

SUMMARY OF ARGUMENT

The Court below correctly found that the ACA is unconstitutional, because its individual mandate is not a valid regulation of economic activity. However, the ACA suffers from a second, equally fundamental constitutional flaw resulting from the ACA's dramatic expansion of the Medicaid Program. The ACA's ambiguity and indefiniteness renders it illegitimate under well-established Supreme Court Spending Clause jurisprudence. The legitimacy of Congress's power to legislate under its spending power rests on whether states voluntarily and knowingly accept the conditions imposed upon them in return for their acceptance of federal funds. For there to be a voluntary and knowing acceptance, Spending Clause legislation requires that federal conditions be sufficiently clear and definite so that elected representatives of their citizens and taxpayers can make an informed decision of whether to accept the funds, being cognizant of the consequences.[4] The ACA's ambiguity prevents states from making a clear and informed choice, requiring

[4] *South Dakota v. Dole*, 483 U.S. 203, 207 (1987) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 & n.13 (1981)).

North Carolina and Minnesota to subject themselves to unknowable and potentially crippling obligations in order to continue their participation in the Medicaid program.

The ACA's radical expansion of Medicaid exceeds Congressional authority under the Spending Clause and thus violates the Tenth Amendment. This is because "'legislation enacted pursuant to the spending power is much in the nature of a contract,' and therefore, to be bound by 'federally imposed conditions,' recipients of federal funds must accept them 'voluntarily and knowingly.'"[5] "States cannot knowingly accept conditions of which they are 'unaware' or which they are 'unable to ascertain.'"[6]

In determining whether statutory conditions are clear enough to ensure a knowing and voluntary acceptance, they must be viewed "from the perspective of a state official who is engaged in the process of deciding whether the State should accept [federal] funds and the obligations that go with those funds."[7] The ACA is too vague and indefinite to satisfy these requirements, providing Federal officials with a virtual blank check in construing and implementing many of its provisions, and extending their reach. Federal officials also have vast discretion to waive key provisions of

[5] *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 297 (2006)(quoting *Pennhurst*).
[6] *Id.* at 296.
[7] *Id.*

the bill, which they have repeatedly done on a temporary, *ad hoc* basis. This ambiguity and indefiniteness makes it impossible for states to be cognizant of the ACA's future consequences, which are inherently unknowable.

These ambiguities and unbridled discretion further make it impossible for states to predict what mandates or fiscal burdens states will incur under the ACA if they remain in the Medicaid program. This ambiguity is aggravated by the fact that the federal government has used rulemaking to render the ACA's apparent limits illusory (such as imposing by rule a controversial provision that was deleted from the ACA prior to its passage). The ACA's vagueness is aggravated by its enormous complexity, massive scope, and unpredictable cost.

ARGUMENT

I.

The Affordable Care Act Is Unconstitutionally Vague and Indefinite

A. The ACA's Ambiguity Renders It Illegitimate Under Spending Clause Jurisprudence, Which Requires That Federal Conditions Be Clear and Definite Enough to Be Contractually Valid and Enforceable

As the Plaintiff States note, "The ACA's dramatic expansion of the Medicaid Program is not a valid exercise of Congress's spending power,"

since its "added burdens, costs, and liabilities" are "incalculable." [8] This ambiguity and indefiniteness makes impossible any knowing and voluntary acceptance of its conditions by the States, violating the principle that "spending power conditions must be truly voluntary."[9]

Indeed, as explained below, the ACA is so ambiguous and indefinite as to render it facially unconstitutional. This vagueness undermines political accountability, aggravating the coercive effects of the ACA.[10] The Supreme Court has repeatedly characterized legislation enacted under the spending power as "in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions."[11] "The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the contract." *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). As

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[8] *Opening/Response Brief of Appellee/Cross-Appellant States*, at 47, 8.
[9] *Id*. at 48.
[10] *See New York v. U.S.*, 505 U.S. 144, 168 (1992) (Spending Clause legislation's legitimacy is based on fact that "where Congress encourages state regulation rather than compelling it, state governments remain responsive to the local electorate's preferences" and "accountable to the people."; "Accountability is thus diminished when, due to federal coercion, elected state officials cannot regulate in accordance with the views of the local electorate."); *Virginia v. Riley*, 106 F.3d 559, 571 (4th Cir. 1997) (a spending-clause law must speak "unambiguously, so that its design is known and the States may marshal their political will in opposition" to expropriations of sovereign rights).
[11] *Pennhurst*, 451 U.S. at 17; *see also Barnes v. Gorman*, 536 U.S. 181, 186 (2002); *Arlington Cent Sch. Dist.*, 548 U.S. at 296.

Plaintiffs-Appellees note, "a State's adoption of a federal regulation in exchange for federal funding must be voluntary 'not merely in theory but in fact.'" *Dole*, 483 U.S. at 211-12. Where, as here, Congress has conditioned billions of dollars in Medicaid funding on the States' acceptance of the ACA's expansion of Medicaid, it has moved from exerting pressure to compulsion, eliminating any voluntary participation by the States.

Moreover, even if one accepts the argument that States could plausibly choose to stop participating in the Medicaid program,[12] the ACA is so vague that it does not – and cannot – allow the States "to exercise their choice knowingly, cognizant of the consequences of their participation."[13]

B. The ACA's Ambiguity Leaves States Unable to Knowingly and Voluntarily Consent To Its Conditions, and Its Vagueness Is Aggravated by the Vast Discretion and Virtual Blank Check It Gives to Federal Officials to Implement and Waive Major Provisions

"There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it."[14] Yet, as reported, "[M]any parts of the [ACA] are ambiguous, requiring regulatory clarification, while lawmakers in other cases deliberately left it to regulators

[12] The ACA fails to speak "unambiguously" about how a State can opt out. *See Pennhurst*, 451 U.S. at 17.
[13] *Dole*, 483 U.S. at 207.
[14] *Pennhurst*, 451 U.S. at 17-18; s*ee Arlington Cent. Sch. Dist.*, 548 U.S. at 296; *Barnes*, 536 U.S. at 186.

to provide the guidance needed for implementation."[15] The indeterminate and open-ended nature of the ACA is illustrated by its 700 grants of power to the HHS secretary to decide what is permitted and 200 instances of discretionary power, in which she "may" decide what is permitted.[16]

A further example of the vagueness and open-endedness of the ACA is its requirement that States "develop service systems" to provide long-term care that "allocate resources for services in a manner that is responsible to the changing needs and choices of beneficiaries . . . ." ACA § 2404(a). The substance of this vague, subjective mandate is delegated to the discretion of the Secretary of Health and Human Services. *Id*.

Similarly, states must provide individuals who are "newly eligible" for Medicaid with "benchmark" coverage. ACA § 2001(a)(2)(A). Yet, the substance of this open-ended mandate too is expressly delegated to the discretion of the Secretary. ACA §§ 2001(c)(3), 1302(a), (b). The Secretary is also empowered to determine, *inter alia*, state enrollment programs for Medicaid and CHIP, ACA § 1413(a), obstetric and smoking cessation services that must be provided by the states, ACA §§ 2301, 4107, and

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[15] Jerry Geisel, *Quick action taken to implement health reform*, Business Insurance, Dec. 13, 2010, at 14 (2010 WLNR 24886985).

[16] Robert Knight, *Tyranny by Decree*, Washington Times, Jan. 3, 2011, at B1 (discussing the ACA's "more than 1,000 power-granting references to" the HHS Secretary).

myriad data collection, evaluation, and reporting requirements that must be carried out by the states, *see, e.g.,* ACA §§ 2001(d)(1)(C), 2701, 2951.

Providing further uncertainty is the impact of early retirees under the ACA's Medicaid expansion provisions, which could potentially add up to five million such retirees to state Medicaid rolls. That financial risk was overlooked in the Medicaid actuary's earlier estimate. As he conceded in January, that "estimated increase in Medicaid enrollment is based on an assumption that Social Security benefits would continue to be included in the definition of income for determining Medicaid eligibility. If a strict application of the modified adjusted gross income definition is instead applied, as may be intended by the Act, then an additional 5 million or more Social Security early retirees would be potentially eligible for Medicaid coverage."[17] More recently, he said the stricter standard was "expected" to apply under the ACA, causing "significantly higher" Medicaid costs for states.[18]

The ACA's Early Retiree Reinsurance Program is already "running out of money" and "will cease accepting applications," raising the possibility

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[17] Richard S. Foster, *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, Testimony before the House Committee on the Budget* (Jan. 26, 2011) at 10 fn. 3.

[18] *See True Cost of PPACA (Patient Protection and Affordable Care Act): Effects on the Budget and Jobs* (Mar. 30 testimony) (2011 WLNR 6323552).

that early retirees will wind up on Medicaid rather than in federally-subsidized private health insurance.[19]

As these examples demonstrate, the ACA's requirements, and particularly what may be expected of the States, are unclear. Without a clear understanding of the ACA's requirements, States cannot exercise their choice knowingly, cognizant of the consequences of their participation. *See Pennhurst*, 451 U.S. at 25. Because the States are not given a clear and informed choice, the Act is not a valid agreement to begin with, and voluntary, knowing acceptance is thus impossible. *See, e.g., Matter of T & B General Contracting*, 833 F.2d 1455, 1459 (11th Cir. 1987) ("Without a meeting of the minds on all essential terms, no enforceable contract arises.").[20] That invalidity makes it unnecessary to reach Florida's equally-valid coercion argument, since the Supreme Court's *Dole* decision shows that courts should only decide the coercion issue after first addressing

[19] *See* F. Vincent Vernuccio, *Under Obama, Running Out of Money Is a Success*, Big Government, May 4, 2011 http://biggovernment.com/vmariano/2011/05/04/under-obama-running-out-of-money-is-a-success/).

[20] See also Restatement (Second) Contracts, § 33; *Pennhurst*, 451 U.S. at 17 (must show acceptance of "the terms of the contract'"); *Brady v. U.S.*, 397 U.S. 742 (1970) (plea agreement "voluntary" only if defendant "fully aware of the direct consequences" and plea not "induced" by "misrepresentation").

whether a law satisfies the Spending Clause's four other requirements, such as the requirement that it be clear and unambiguous.[21]

[21] *See Dole*, 483 U.S. at 208-09 (addressing whether a statute satisfied the first four requirements for spending-clause legislation, such as whether its conditions were "clearly stated," before addressing the State's coercion argument, even though the State did not "seriously" argue that any of those four requirements were violated, but instead argued coercion); *id.* at 214-16 (O'Connor, J., dissenting) (arguing that the statutory provision was unconstitutional based on one of those four requirements, in response to an argument made in the amicus brief of the National Conference of State Legislators, even though the State itself did not make that argument); *Kansas v. U.S.*, 214 F.3d 1196, 1199-1200 (10th Cir. 2000) (addressing "the first four restrictions outlined in *Dole*," even though Kansas did "not seriously argue" that they were violated, before addressing coercion; ruling on statute's ambiguity even though "Kansas fails to assert the alleged invalidity"). Contractually, the Act's ambiguity is a threshold question that should be decided first before the related issue of coercion. *Riehl v. Cambridge Court*, 226 P.3d 581, 587 (Mt. 2010)("ambiguity" was "threshold" question to be decided before contractual defenses like unconscionability); *Tri-M Group v. Sharp*, -- F.3d --, 2011 WL 941602 (3d Cir. 2011) (deciding "threshold" question that was alternative basis for state's constitutional argument first, even though state had not raised it below); *Harris v. Blockbuster*, 622 F.Supp.2d 396 (N.D. Tex. 2009) (where contract was so indefinite as to be illusory, court invalidated it on that ground, and did not reach whether it was unconscionable). Unlike in *Dole*, the States in this case have raised each of the other *Dole* factors, including the issue of the ACA's ambiguity. *Memorandum In Support of Plaintiffs' Motion for Summary Judgment* at 36, 42, 44-45 (11/4/2010)(Tr. Doc. 80) (ACA "violates the principle that conditions on federal funds must be unambiguous," imposing "vast potential liabilities that cannot even be projected"); *compare LaRocca v. Gold*, 662 F.2d 144, 147-49 (2d Cir.1981) (ruling based on issue not briefed on appeal, where the issue had been raised in the trial court). Even had they not done so, their Spending-Clause challenge implicates both issues. *Barefoot Architect v. Bunge*, 632 F.3d 822, 834-35 (3d Cir. 2011) (ruling on a contractual issue not raised below, because it was related to one that was).

Even if the ACA's text were fully understood, many of its requirements would ultimately be unknowable due to the unprecedented discretion granted to federal officials to implement and define the content of key provisions, and their ability to waive key provisions of the law without reference to any predetermined criteria.

Courts have long recognized that "incomprehensible" language, "hiding" of disadvantageous terms in obscure clauses, and other forms of "unfair surprise" can negate "assent to the terms of the contract," [22] nullifying consent.[23] The ACA is even worse than that, since key requirements of the law can be waived, extended, or redefined by HHS, as we explain below.

1. The Federal Government Has Repeatedly Waived Key Features of the Law, on a Temporary, *Ad Hoc* Basis.

Indeed, States cannot reliably predict what the effects of the ACA will be on their state because even its most important features can apparently be waived by federal officials. For example, the State of "Maine received a three-year waiver of federal rules, contained in the 2010 health-care law, that

[22] *Willie v. Southwestern Bell*, 549 P.2d 903, 906 (Kan. 1976).
[23] *Lee v. State Farm*, 57 Cal. App.3d 458, 470 (Cal. App. 1976) (Friedman, J., concurring) (obscurity of "fineprint sleepers" can "nullify" "consent").

require insurers to spend at least 80 percent of premiums on patient care" [24] even though this provision was a "key" inducement to passage of the Act.[25] In granting the waiver, HHS cited the "likelihood" that the requirement would end up "destabilizing the Maine individual health insurance market" if implemented.[26] Similar waiver requests from three other states remain pending.[27]

The fact that key ACA provisions could destabilize a state's health care system–potentially resulting in thousands of additional people losing their insurance and ending up on Medicaid or state exchanges–is a huge potential cost for a state under the ACA, one seemingly not addressed in ACA cost studies. Even so, given the potential for a waiver, States cannot determine whether such costs are certain to occur.

The Secretary's broad discretion in implementing the ACA is further illustrated by the vast number of waivers she has granted of key

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[24] Drew Armstrong, *Maine Gets Waiver from Health Premium Rules*, Washington Post, March 9, 2011, at A4, www.washingtonpost.com/wp-dyn/content/article/2011/03/08/AR2011030805908.html.
[25] *See* Office of Speaker Nancy Pelosi, *Key Provisions That Take Effect Immediately*, May 3, 2010, at 2 (http://docs.house.gov/energycommerce/IMMEDIATE_PROVISIONS.pdf); HHS, *Key Provisions That Take Effect Immediately* (www.healthreform.gov/reports/keyprovisions.html).
[26] *Id.*
[27] *Id.*

requirements.[28] The Obama Administration has granted almost one thousand waivers of ACA rules.[29] Although the basis for these waivers is not currently known to the public, such waivers do not appear to be based on pre-determined criteria, but rather on political favoritism. Indeed, a disproportionate number of waivers have been granted to unions like the SEIU, [30] Teamsters, UFCW, IBEW, and CWA.[31] In fact, 733 unions and companies with over 2 million employees have received a waiver of just one ACA provision, its ban on annual coverage limits.[32]

Furthermore, these waivers are not permanent, lasting "only [] one year," adding further uncertainty.[33] Moreover, these *ad hoc,* temporary waivers were granted as a political concession to avoid people losing their

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[28] *See* Philip Hamburger, *Are Health-Care Waivers Unconstitutional?*, National Review, Feb. 8, 2011, (www.nationalreview.com/articles/259101/are-health-care-waivers-unconstitutional-philip-hamburger).

[29] *Need a Waiver from Obamacare? Get In Line*, Detroit News, Jan. 18, 2011, at A13.

[30] Hamburger, *Are Health-Care Waivers Unconstitutional?, supra*.

[31] Michelle Malkin, *Obamacare Waivers to Those Who Do Favors*, Washington Examiner, Jan. 30, 2011, at 45 (http://washingtonexaminer.com/opinion/columnists/2011/01/obamacare-waivers-those-who-do-favors).

[32] HHS, *Helping Americans Keep the Coverage They Have and Promoting Transparency*, available at www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html.

[33] HHS, *Helping Americans Keep the Coverage They Have and Promoting Transparency*, supra.

current coverage. [34] If these waivers are not made permanent, States may face substantial additional costs from people who lose their employer-provided health insurance[35] (due to factors such as increased premium costs[36]) and end up on state-subsidized Medicaid programs or state exchanges. The Secretary's vast discretion in writing and waiving ACA rules makes predicting these costs simply impossible, particularly considering that many rules that HHS was supposed to issue to implement the ACA's vague requirements either have no statutory deadline,[37] or have deadlines that were ignored.[38]

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[34] *See* Reed Abelson, *Waivers Aim at Talk of Dropping Health Coverage*, N.Y. Times, Oct. 7, 2010, at B1 (Obama Administration "tried to defuse stiffening resistance" to ACA through waivers, "as part of a broader strategic effort" to mollify critics "at a time when the midterm elections are looming"; White House official admitted "concessions given to companies and insurers reflected attempts to avoid having people lose their current coverage"; "politics from state to state" cited in debate over how stringently to enforce ACA mandates) (www.nytimes.com/2010/10/07/business/07insure.html)

[35] In the absence of waivers, some employers will likely drop their health care plans. *See Repeal Is the Ultimate Obamacare Waiver*, *supra* (Fowler Packing Co. sought "waiver because their low-wage agricultural workers would have lost the basic coverage" they had received "for years").

[36] *Cf.* Don Surber, *Obamacare Leads to 47% Premium Hike*, Charleston Daily Mail, Oct. 16, 2010, at 9:00 AM (http://blogs.dailymail.com/donsurber/archives/22999).

[37] *See* Congressional Research Service, *Deadlines for the Secretary of Health and Human Services in the Patient Protection and Affordable Care Act*, Oct. 1, 2010, at 1 (ACA rules "generally" have "flexible deadlines or no deadline at all") (available at

Additionally, HHS has used its rule making authority to so narrowly construe the grandfather provision that it will not apply to "most employers,"[39] and the government admits that many will lose their eligibility.[40] Since employers that lose their grandfather-clause exemption are then subject to "costly mandates,"[41] some may terminate their insurance, dumping their employees onto Medicaid or state exchanges.[42]

By leaving such vast discretion to the Secretary to implement and/or waive major provisions, the ACA leaves States unable to know what is

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http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=54103bf6-ae3a-47be-916e-72548ba34b5b).

[38] *See id.* at 3-5 ("no public information found" for many rules that were due to be issued by now); Sen. Tom Coburn, *HHS Administrative Failure: HHS Failed to Meet a Third of Mandated Deadlines Under New Federal Health Care Law*, Oct. 4, 2010, available at http://coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=f6efe11e-39bc-4532-a586-d1ad0b608e80.

[39] George Pantos, *Manage Rising Health Care Costs*, Atlanta Journal-Constitution, Sept. 20, 2010, at A21 ("rules governing 'grandfathered' insurance plans" released last year by HHS" are "so onerous, though, that most employers will find it impossible to follow them.")

[40] *See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan*, 75 FR 34538, 34552 (June 17, 2010) (employer relinquishing grandfather status estimated at between 33% to 69% for all employers, with large employers ranging from 29% to 64%).

[41] *Manage Rising Health Care Costs, supra.*

[42] *See* Greg Johnson, *Employers Likely to Drop Health Insurance Under Health Care Law*, Knoxville News Sentinel, Sept. 3, 2010 (Actuary for Medicaid and Medicare estimates that "14 million workers and their families" will end up "losing employer coverage" due to the ACA) (www.knoxnews.com/news/2010/sep/03/employers-likely-to-drop-insurance-under-health/).

expected of them, making knowing acceptance of its terms impossible. Indeed, the amount of discretion granted to the Secretary further reveals the illusory nature of the ACA.

2. By Leaving the Federal Government With Unbridled Power to Expand States' Medicaid Obligations, the ACA Violates Principles Forbidding Illusory and Indeterminate Contracts

The illusory nature of the ACA is evidenced by the unbridled authority granted to the Secretary by the ACA. Indeed, backers of the Act have called the ACA a mere "starter home" to be expanded and fleshed out in the future,[43] one that will make Medicare seem like a "model of simplicity" by comparison.[44] Thus, it will "end up covering much more than" people think.[45] Indeed, the ACA has been described as a "skeleton" to be "fleshed out" through administrative fiat.[46] For example, the ACA left the HHS with such unbridled authority that it wrote rules implementing

[43] Sen. Tom Harkin, *Health Legislation A Solid Foundation to Build Upon*, Wilmington News-Journal, Dec. 30, 2009, at A18 (ACA's passage is just "the opening act," leaving "plenty of room for additions").
[44] Jacob Hacker, *Health Reform 2.0*, American Prospect, Sept. 1, 2010, at A25 ("Sen. Tom Harkin put the point well when he described the health bill as a 'starter home.' What Harkin neglected to mention is that the home isn't built yet").
[45] Nick Gillespie, *Obamacare and Mission Creep Redux: Sen. Harkin Says Obamacare "is a Starter Home"*, Reason, Dec. 21, 2009. (http://reason.com/blog/2009/12/21/obamacare-mission-creep-redux).
[46] *See* Insurance Barn, *2 Options If You Lose Your Group's Grandfathering By Changing Contribution Levels*, Feb. 11, 2011 (PPACA's "skeleton" has been "fleshed out" with rules that "nullified" its grandfather clause exemption for many employers).

provisions (such as end-of-life planning) that had earlier been removed from the Act in response to public outcry.[47]

But the federal government does not have unbridled authority under the Spending Clause to make any amendments to Medicaid, no matter how coercive or arbitrary, or how far they go toward fundamentally changing the contractual bargain between the federal government and the States. *See, e.g.*, 1 Williston on Contracts § 4:21 (4th ed. 2010) ("reservation in either party of a future unbridled right to determine the nature of the performance" renders contract "too indefinite for enforcement"). Such unbridled power vested in one party makes a contract illusory and non-enforceable under *Pennhurst* and its progeny. *See also* Restatement (Second) Contracts, § 2 *cmts. a & e*.

C. The ACA's Costs Are Extremely Unpredictable, Further Preventing States from Being Able to Voluntarily and Knowingly Consent

[47] *See, e.g.*, Robert Pear, *Obama Returns to End-of-Life Plan That Caused Stir*, N.Y. Times, Dec. 26, 2010, at A1 ("When a proposal to encourage end-of-life planning touched off a political storm over 'death panels,' Democrats dropped it from legislation to overhaul the health care system. But the Obama administration will achieve the same goal by regulation, starting Jan. 1. . . .the government will pay doctors who advise patients on options for end-of-life care, which may include advance directives to forgo aggressive life-sustaining treatment.") (www.nytimes.com/2010/12/26/us/politics/26death.html).

As the Congressional Research Service notes, "Given the complexity of the health care system prior to PPACA, and the many changes generated by the new law, the impact on states will vary and will be difficult to estimate, even with the best modeling."[48] Moreover, the ACA's Medicaid costs will vary widely among States:

> "State impacts will vary based on current coverage levels across states, generosity of the state's Medicaid/CHIP eligibility rules and other state-financed coverage programs, existing private insurance regulatory authority, standards, and resources, current state fiscal health, and other factors. Such variation creates difficulties in accurately estimating costs across states. There are substantial differences among states in terms of the percentages of the states' populations that would meet the definition of "newly eligible" under the mandatory Medicaid expansion as compared to previously eligible individuals. Federal matching rates to share in the cost of Medicaid/CHIP coverage for these individuals under health reform will vary by state, by year, and by eligibility status."[49]

Moreover, "Beyond the extra Medicaid costs that states are certain to incur, there are some other state Medicaid cost increases that are probable, but not definite," such as "payments to so-called Disproportionate Share Hospitals (DSH) and payments to specialist physicians."[50]

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[48] CRS, *Memorandum re: Variation in Analyses of PPACA's Fiscal Impact on States*, Sept. 8, 2010, at 1 (Tr. Doc. 80, Ex. 36).
[49] *Id.* at 7.
[50] Edmund Haislmaier & Brian Blase, *Obamacare: Impact on States*, Heritage Foundation, July 1, 2010, available at www.heritage.org/Research/Reports/2010/07/Obamacare-Impact-on-States.

The ACA has already proven much more expensive than was predicted just a short time ago. Soon after its passage, the CBO increased its estimate of the ACA's costs to the federal government alone by $115 billion.[51] Its cost to state governments also grew. For example, the ACA provided $5 billion for states to run high-risk pools. But this number turned out to be grossly insufficient to cover state costs. "In June, Richard Foster, Medicare's chief actuary, told *The New York Times* that the $5 billion will run dry as early as 2011," and "there is enough funding to cover only about 200,000 of those people, or less than 3 percent. . . .ObamaCare leaves states on the hook for the rest of the tab."[52]

These uncertainties in the ACA's costs matter enormously because of the massive scope of its expansion of state Medicaid obligations[53] and the ACA's vast delegation of policymaking to federal officials.[54] "Obamacare's unfunded mandates are a fiscal time bomb set to explode state balance sheets

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[51] *Another Empty Pledge*, Las Vegas Review-Journal, June 17, 2010, at 6B.
[52] Peter Suderman, *Rogue States*, Reason Magazine, Oct. 2010 (http://reason.com/archives/2010/09/14/rogue-states).
[53] *See* Opening/Response Brief at 53 (Medicaid is already 26% of Florida's budget).
[54] *See Reno v. ACLU*, 521 U.S. 844, 864 (1997) ("vagueness" relevant to "overbreadth inquiry"); *Botts v. State*, 604 S.E.2d 512, 515 (Ga. 2004) ("broad language" made law's imprecise contours "too vague" to be constitutional, even though those words had a "dictionary definition," especially since their broad reach had the effect of delegating "basic policy matters" to officials on "an *ad hoc*" basis).

across the country starting in 2014," notes the Heritage Foundation.[55] The ACA will force States to "massively expand their already burdensome Medicaid rolls" to include "all non-elderly individuals with family incomes below 138 percent of the federal poverty line."[56] "But that is just the benefit costs. Obamacare does not pay for any of the costs necessary to administer the expansion of the Medicaid rolls, rolls that are expected to increase by approximately 50 percent in states like Nevada, Oregon, and Texas"; indeed, "just the administrative costs of the Obamacare Medicaid expansion will cost almost $12 billion by 2020." [57]

While the ACA's precise costs are unknown, preliminary estimates are staggering. In Texas alone, "the Medicaid expansion may add more than 2 million people to the program and cost the state up to $27 billion in a decade," while Florida faces "an additional $5.2 billion in spending between 2013 and 2019 and more than $1 billion a year beginning in 2017," and California faces billions in "annual costs"; "The seven-year cost of the

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[55] Heritage Foundation, *Morning Bell: The Obamacare Burden To Your State Budget*, November 12th, 2010 at 9:22am (http://blog.heritage.org/2010/11/12/morning-bell-the-obamacare-burden-to-your-state-budget/).

[56] *Id*.

[57] *Id., citing Haislmaier & Blase, supra* note 21; accord Peter Suderman, *Rogue States*, Reason Magazine, Oct. 2010 ("ObamaCare also fails to cover the administrative costs associated with" the expansion) (http://reason.com/archives/2010/09/14/rogue-states).

Medicaid expansion in Indiana is estimated to be between $2.59 billion and $3.11 billion, with 388,000 to 522,000 people joining the state's Medicaid rolls," while "Obamacare will result in nearly one of five Nebraskans being covered by Medicaid.[58]

The ACA leaves states obligated to cover up to 12 million additional people already eligible for Medicaid who did not previously enroll, some of whom will likely enroll as a result of the ACA penalty for not having health insurance.[59] Many studies of its cost, such as a Kaiser study cited by ACA supporters, failed to take this cost into account, looking at the costs of newly-eligible people, not people who were already eligible but did not sign up prior to the ACA.[60] Its individual mandate requires many of these

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[58] Lanhee Chen, *How Obamacare Burdens Already Strained State Budgets*, Heritage Foundation, Nov. 10, 2010 (Backgrounder #2489) (available at http://ww.heritage.org/Research/Reports/2010/11/How-Obamacare-Burdens-Already-Strained-State-Budgets) (citing estimates by the Florida Agency for Health Care Administration and the California Legislative Analyst's Office, and a study by the Milliman economists hired by Nebraska and Indiana).

[59] Brian Blase, *Obamacare and Medicaid: Expanding a Broken Entitlement and Busting State Budgets*, Heritage Foundation, Jan. 19, 2011 (www.heritage.org/research/reports/2011/01/obamacare-and-medicaid-expanding-a broken -broken-entitlement-and-busting-state-budgets) (citing a study by the National Institute for Health Care Management).

[60] Michael Cannon, *New Cato Study: ObamaCare's Medicaid Mandate Imposes Staggering Costs on States*, Cato Institute, Jan. 19, 2011 ("the Kaiser Family Foundation's projections are lower because" they did not take into account "people who were eligible for Medicaid but not enrolled under the pre-ObamaCare rules," despite studies showing that the ACA "will

people to obtain individual health insurance – which effectively forces them into Medicaid, since the ACA denies people below the poverty line any subsidy for their insurance premiums, even while subsidizing the insurance of people with incomes up to four times the poverty level.[61] "ObamaCare provides states with zero additional federal financial support for *new enrollees among those eligible for Medicaid under the old laws*. . . estimates of those costs range from just $11.7 billion for California to a high of $65.5 billion in New York."[62]

Calculating those costs is subject to great uncertainty, however, because people don't sign up for Medicaid for a variety of reasons that affect their healthcare costs, such as good health, ignorance, or the availability of other insurance (such as employer-provided health insurance that they will eventually lose due to the ACA, resulting in their ending up on Medicaid[63]).

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encourage people to enroll in Medicaid") (www.cato-at-liberty.org/new-cato-study-obamacares-medicaid-mandate-imposes-staggering-costs-on-states/).

[61] *See* ACA § 1402(b); Opening/Response Brief at 67-68.

[62] Jagadeesh Gokhale, *Estimating ObamaCare's Effect on State Medicaid Expenditure Growth*, at 1-2 (Cato Institute 2010) (www.cato.org/pubs/researchnotes/WorkingPaper-4.pdf).

[63] *See* Reed Abelson, *Insurer Cuts Health Plans as New Law Takes Hold*, N.Y. Times, Oct. 1, 2010, at B1 (insurer that "provides coverage to about 840,000 people" through employers stopped providing health insurance in response to the ACA); *cf.* Emily Ramshaw, *Child-Only Insurance Vanishes, a Health Act Victim*, N.Y. Times, Apr. 1, 2011, at A23.

Under traditional Medicaid, states' plans differed widely, as long as a state met minimum requirements. But the ACA prohibits states from tightening their eligibility rules, even though that is a "typical way" to control rising costs in a recession,[64] when revenue falls and Medicaid "enrollment surges."[65] In other words, the ACA locks the states in to choices they had been led to believe could be changed at will, punishes states for their past generosity, and renders their future expenses more unpredictable.

The indefinite nature of the States' long-run financial commitments to Medicaid makes the ACA on its face contractually infirm and hence unconstitutional.

D. The ACA's Complexity Accentuates its Vagueness

The ACA's sheer complexity is aptly, but only partially, captured by the chart provided by minority staff of the Joint Economic Committee (JEC), which is found at the end of this brief in the Addendum that follows the Certificate of Service. (It also is found in the trial record,[66] and on the

[64] *See Rogue States*, *supra*, note 62 .
[65] *See* Christine Vestal, *Medicaid: How It Works, What's Being Proposed*, Newark Star-Ledger, Apr. 24, 2011, at 8.
[66] Doc. 132, p. 5 (amicus brief of Gov. Pawlenty, 11/19/2010).

Internet.[67]) While that "chart displays a bewildering array of new government agencies, regulations and mandates," the reality is even more complicated, since "committee analysts could not fit the entire health care bill on one chart. 'This portrays only about one-third of the complexity of the final bill. It's actually worse than this.'"[68]

This enormous complexity accentuates its vagueness,[69] and makes it all but impossible to comprehend "from the perspective of a state official who is engaged in the process of deciding whether the State should accept [federal] funds and the obligations that go with those funds." *Arlington*

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[67] Joint Economic Committee, Republican Staff, *Your New Health Care System,* http://jec.senate.gov/republicans/public/?a=Files.Serve&File_id=5ee16e0f-6ee6-4643-980e-b4d5f1d7759a; *see Bryant v. Avado Brands*, 187 F.3d 1271, 1280-81 (11th Cir. 1999) (judicially noticing SEC web site content); *Livermore v. Heckler*, 743 F.2d 1396, 1403 (9th Cir. 1984) (citing JEC staff report).

[68] *See* JEC Republicans, *America's New Health Care System Revealed: Updated Chart Shows Obamacare's Bewildering Complexity*, Committee News, Aug. 2, 2010 (quoting Rep. Brady), available at http://jec.senate.gov/republicans/public/index.cfm?p=CommitteeNews&ContentRecord_id=bb302d88-3d0d-4424-8e33-3c5d2578c2b0.

[69] *Cheek v. U.S.*, 498 U.S. 192, 199-200 (1991)("complexity" of statutes can make "it difficult" for citizens "to know and comprehend" them); *O'Brien v. Star Gas Propane*, 2006 WL 2008716, *12 (N.J. App. 2006) ("technical and cumbersome" terms made release too "difficult to understand"); *Lovey v. Regence Blue Shield*, 72 P.3d 877, 883 n.2 (Id. 2003) ("complex legalistic language" can result in "unfair surprise" and procedural unconscionability); *Jerry Rossman Corp. v. C.I.R.*, 175 F.2d 711, 713-14 (2nd Cir. 1949) (price control rules were so complex that "innocent violations" could occur despite "due care," making penalties tax-deductible).

Cent. Sch. Dist., 548 U.S. at 291. The magnitude of the complexities make it virtually impossible for state officials to "exercise their choice knowingly, cognizant of the consequences of their participation." *Dole*, 483 U.S. at 207.

E. The ACA's Ambiguity and Violation of States' Reasonable Expectations Make Its Pressure More Impermissibly Coercive

Although Congress can pressure states to adopt federal policies through the carrot of Spending Clause legislation to a certain extent, it cannot "coerce" them into doing so. The Supreme Court "'has 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.'"[70] "The more massive the amount of federal funding that Congress threatens to withhold, the greater the need for Congress to demonstrate a reasonable relationship between the conditions and the funds."[71] Such a reasonable relationship is hard to show when the statute itself is vague, like the ACA.

Moreover, "fraud and physical duress are not the only grounds upon which courts" find contracts impermissibly coercive.[72] Courts often refuse to enforce "vague or obscure contractual language"[73] in contracts of

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[70] *Opening/Response Brief* at 49, *quoting Dole*, 483 U.S. at 211-12.
[71] *Opening/Response Brief* at 51-52.
[72] *Henningsen v. Bloomfield Motors*, 161 A.2d 69, 85-86 (N.J. 1960).
[73] *Conseco Finance v. Wilder*, 42 S.W.3d 331, 342 n.20 (Ky. App. 2001).

adhesion, "prepared entirely by one party to the transaction for the acceptance of the other" on a "take it or leave it basis."[74] That accurately describes the ACA. (Indeed, the ACA is worse than an adhesion contract, since it not only spans 2700 pages of complicated requirements, but also gives federal officials enormous power to expand the statute's reach through rulemaking, fundamentally rewriting the "contract"). Consent is deemed absent[75] where the provision violates a party's "reasonable expectations."[76] The ACA violates the States' reasonable expectations, both by imposing indeterminate new obligations, and by locking them into previously-made coverage decisions that they had been led to believe were voluntary and alterable at will.[77] It also exploits their loss of bargaining power,[78]

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[74] *Stevens v. Fidelity & Casualty Co.*, 377 P.2d 284, 297 (Cal. 1962).

[75] *Leonard & Butler v. Harris*, 653 A.2d 1193, 1199 (N.J. App. 1995) (no legally cognizable "consent"); *Blair v. Pitchess*, 486 P.2d 1242, 1254-55 (Cal. 1971) ("consent" to adhesion contract was "ineffective" for constitutional purposes).

[76] *See Riehl*, 226 P.3d at 584 ("contract of adhesion will not be enforced" if terms "are not within the reasonable expectations of the party"); *Gray v. Zurich Insurance*, 419 P.2d 168, 172 (Cal. 1966). Even outside the context of adhesion contracts, changes to existing contracts that violate reasonable expectations can breach the covenant of good faith and fair dealing. Restatement (2nd) of Contracts, § 205 & cmts. (a) & (d). This is especially true in ongoing relational contracts, *see* Carmen D. Caruso, *Franchising's Enlightened Compromise: The Implied Covenant of Good Faith and Fair Dealing*, 26-SPG Franchise L.J. 207, 209 (2007), a category that encompasses state-federal cooperative programs like Medicaid.

[77] *Opening/Response Brief* at 8-9 (discussing how the ACA forbids states to tighten their existing Medicaid eligibility and coverage limits).

predicating coverage of their poorest citizens on states' inability to withdraw from Medicaid.[79] (The fact that the ACA makes fundamental changes to existing Medicaid programs that states have come to depend on makes it subject to tougher scrutiny than various programs previously upheld by the courts, which involved new programs that states were freer to reject.[80])

II.

The ACA's Individual Mandate Cannot Be Justified Under a Cost-Shifting Rationale, and Exceeds Congress's Power Under the Commerce Clause

The ACA's mandates will increase–not reduce–cost-shifting. "According to the Congressional Budget Office, around half of the people

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[78] States' healthcare systems are now "driven largely" by programs like Medicaid, *see* Mark E. Douglas, *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform*, 5 Ind. Health L. Rev. 277, 332 (2008), and have evolved to rely and depend on it. *See also Opening/Response Brief* at 6 (discussing states' growing dependence on Medicaid). Thus, states have little choice but to remain in Medicaid, even if the ACA's changes to Medicaid violate their reasonable expectations, leaving them with unequal bargaining power vis-à-vis the federal government. This is significant, because contractual modifications are subject to greater scrutiny when bargaining power has "shifted away" from a party. *See* Daniel J.H. Greenwood, *Beyond the Counter-Majoritarian Difficulty*, 53 Rutgers L. Rev. 781, 819 fn. 90 (2001)(discussing duress), *citing, e.g., Alaska Packers v. Domenico*, 117 F. 99, 102 (9th Cir. 1902).

[79] *Opening/Response Brief* at 52.

[80] New conditions that violate a party's reasonable expectations can be invalidly coercive even in the context of an at-will contract. *Reiver v. Murdoch & Walsh*, 625 F.Supp. 998, 1013 (D. Del. 1985) ("cases have recognized the validity of claims or defenses based on economic duress involving the threatened termination of at-will employees").

who are expected to become newly insured under the new law will be enrolled in Medicaid. But Medicaid payments to doctors and hospitals are so low that the program creates a cost shift of its own. In fact, a long line of academic research shows that low rates of Medicaid reimbursement translate into higher prices for the privately insured."[81]

So it is deeply ironic that the Government justifies the ACA's individual mandate by claiming that uninsured people "shift significant costs to other participants" in the healthcare system.[82] But researchers have found that "there is no credible evidence of a cost shift of any substantial consequence, either within state boundaries or across state lines."[83] Similarly, a 2007 study co-authored by MIT's Jonathan Gruber – who advised the ACA's sponsors[84] – "found no evidence that doctors charged insured patients higher fees to cover the cost of caring for the uninsured."[85] Indeed, Gruber found that doctors earn "'more on uninsured patients than on insured patients with comparable treatments,'" while another study found

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[81] John F. Cogan, et al., *Obamacare and the Truth About 'Cost-Shifting'*, Wall Street Journal, Mar. 11, 2011, at A15.
[82] Brief for Appellants at 10.
[83] Cogan, *Obamacare and the Truth About 'Cost-Shifting'*, *supra*.
[84] Ed Morrissey, *Did HHS Help Hide Gruber's Status As Paid Shill?*, Daily Caller, Jan. 29, 2010 (http://dailycaller.com/2010/01/29/did-hhs-help-hide-gruber%E2%80%99s-status-as-paid-shill/).
[85] *Obamacare and the Truth About 'Cost-Shifting'*, *supra.*

that "'uninsured patients as a group still paid a higher percentage of charges, on average, than Medicare and Medicaid.'" [86]

More importantly, "the economics of markets for health services suggests that any cost shifting that may occur is unlikely to affect interstate commerce. Because markets for doctor and hospital services are local--not national--the impact of cost shifting will be borne where it occurs, not across state lines."[87] Even *Gibbons v. Ogden*, which "described the Federal commerce power with a breadth never yet exceeded,"[88] recognized that "health laws of every description" were beyond the reach of the Commerce Clause. [89]

CONCLUSION

For the foregoing reasons, the trial court's invalidation of the ACA should be upheld.

Dated: May 10, 2011

Respectfully submitted,

Hans Bader

/s/ Hans F. Bader

[86] Michael Cannon, *Are the Uninsured Free-Riding*, Cato Institute, Aug. 6, 2008 (www.cato-at-liberty.org/are-the-uninsured-free-riding/) (quoting and linking to studies).
[87] Cogan, *Obamacare and the Truth About 'Cost-Shifting'*, *supra*.
[88] *Wickard v. Filburn*, 317 U.S. 111, 120 (1942).
[89] *Gibbons*, 22 U.S. 1, 203 (1824).

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), I hereby certify that this brief contains 6,952 words, excluding the portions of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and has been prepared in a proportionally spaced typeface using Microsoft Word 2007 in Times New Roman 14-point font.

/s/ Hans Bader
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CERTIFICATE OF SERVICE

I hereby certify that, on May 11, 2011, I filed the foregoing brief with this Court, by causing a copy to be electronically uploaded and by causing the original and six paper copies to be delivered by FedEx next business day delivery. I further certify that I caused this brief to be served on the following counsel by electronic mail, and by hard copy via first class mail on the counsel denoted with asterisks:

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ADDENDUM

ACA CHART BY JOINT ECONOMIC COMMITTEE MINORITY STAFF

ENTITLED "YOUR NEW HEALTH CARE SYSTEM"

(The chart is found on the following page[90])

[90] This document is also in the trial record at Doc. 132, p. 5 (amicus brief of Gov. Pawlenty, filed on Nov. 19, 2010).

Your New Health Care System

President §§ 3012, 3024, 3403, 4001, 8002, 10320

Homeland Security Department §1411

Social Security Administration §1411

State Protection & Advocacy Systems §8002

Office of Personnel Management §§1334, 10104

Office of Multi-State Qualified Health Plans §1334, 10104

Interagency Working Group on Health Care Quality §3012

Black Lung Benefits Act §1556

Labor Department §§1001, 1302, 1311, 1511, 1512, 1513, 6605, 10101, 10106

Hours of Service Determination for Calculating Employer Mandate Penalty §§1513, 10106

Rules for Insurance Claims Appeals §1001, 10101

Justice Department §6703

PCORI §§6301, 10602

PCORI Board of Governors §6301

PCORI Website §6301

PCORI Methodology Committee §6301

PCORI Trust Fund §6301

PCORI Expert Advisory Panels §6301

Other New Regulatory Programs 4

Interagency Pain Research Coordinating Committee §4320

Medicare Part A Trust Fund §§3026, 3403, 6301,9015

IPAB §3403, 10320

IPAB Consumer Advisory Council §§3403, 10320

Medicare Part B Trust Fund §3026, 6301

Life Independence Accounts §8002

CLASS Independence Advisory Council §8002

Eligibility Assessment System §8002

Other New Grant Programs 59

CLASS Independence Fund §8002

CLASS Program §8002

Personal Care Attendants Workforce Advisory Panel §8002

CLASS Independence Benefit Plan §8002

CLASS Independence Fund Board of Trustees §8002

Cures Acceleration Network Review Board §10409

Cures Acceleration Network §10409

NIH §§4305, 6301, 10409

National Public Education Campaign on Prevention & Health Promotion §4004

Community Preventive Services Task Force §4003

National Oral Health Public Education Campaign §4102

National Diabetes Report Card Program §10407

National Partnership on Prevention & Health Promotion §4004

CDC §§1001, 4003, 4004, 4102, 10407

National Diabetes Mortality Statistics Education Training Program §10407

Other New Bureaucracies 22

Prevention & Public Health Fund §4002

National Prevention, Health Promotion, & Public Health Council §4001

Surgeon General §4001

Prevention Website §4004

Website "Transparency in Government" §1552

Advisory Group on Prevention, Health Promotion, and Integrative and Public Health §4001

Public Health Service §§3011, 4002, 4302

Health Care Quality Website §§3011, 3012

Health IT Policy Committee §1561

Public Health Quality & Efficiency Measures Development Program §§3013, 10304

National Health Strategy & Priorities Office §3011

National Health Disparities Data Collection & Reporting System §4302

Secretary Health & Human Services

Treasury Department §§1311, 1331, 4002, 8002, 10104

IRS §§1401, 1402, 1411, 1412 1414, 1421, 1501, 9004, 9005, 10105, 10901; HCERA §§1401, 1402

Office of Tax Analysis §§1331, 10104

National Academy of Sciences §5605

Key National Indicator System Implementation Institute §5605

Commission on Key Indicators §5605

Special Interest Provisions 19

Congress Members & Personal Staff Mandate: Only Exchange Coverage §1312

Congress §§1312, 1411, 3311, 5605, 8002

Comptroller General §§1313, 1322

MedPAC §2802

GAO §§1401, 3001, 3403, 6301, 10105, 10320

Vital Statistics Agencies §10407

State Surveyors §6703

Optional Basic Health Program §§1331, 10104

Other New Demonstration & Pilot Programs 26

Advisory Board on Elder Abuse, Neglect, & Exploitation §6703

Multi-Disciplinary Panels on Improving Long-Term Care §6703

National Training Institute for Federal and State Surveyors §6703

Elder Abuse, Neglect, & Exploitation Forensic Centers §6703

Elder Justice Coordinating Council §6703

AHRQ §3012, 3013, 6031

US Preventive Services Task Force §1001

Essential Health Benefits Package §§1001, 1201, 1301, 1302 — Bronze, Silver, Gold, Platinum

States §§1311,1331, 1333,1341, 10104, 10407

NAIC §§1333, 1341, 10104

Health Care Choice Compacts §§1333, 10104

Reinsurance Program §§1341, 10104

US Territories §1323; HCERA §1204

Value-Based Insurance Design & Coverage of Preventive Health Services §1001

Qualified Health Plans §§1301, 1302, 1311, 10104

Privacy Study §1411

Health Insurance CO-OP §§1322, 10104

CO-OP Advisory Board §1322, 10104

Private Purchasing Council §1322

Eligibility Determinations §1411

Government Health Benefit Exchanges §§1201, 1301,1302, 1311, 1312, 1313, 1321, 1323, 1334, 1411, 1413, 10104; HCERA §1204

Internet Portal §1311

Small Business Health Options Program §1311

Data Collection §1311

Risk Corridors §1342

HHS Inspector General §§1313, 8002, 10104

Insurance Mandates §§1001, 1101, 1201, 1281, 10101, 10103; HCERA §2301 — 17

Individual Market §1201, 1301, 1304, 1343

Small Group Market §§1301, 1304, 1342

Mandatory Worker Auto-Enrollment §1811

Employer Mandate: Provide Health Insurance §§1513, 10106; HCERA §1003

MEWA Health Plans §§1301, 6605

W2 Health Insurance Disclosure §9002

Large Group Market §§1201, 1301, 1511

Large Employers §§1304, 1511, 1512, 1513, 1514, 10106

Self-Insured Health Plans §1301

Medicare Part C & Part D Insurers §3311

Health Insurance Companies Mandates, Regulations, Required Benefits, & Taxes §§1001, 1201, 1252, 1301, 1334, 1341, 3311, 9001, 9010, 10101, 10104, 10901, 10908; HCERA §§1401, 1406

Employers Mandates, Regulations, & Taxes §§1511, 1512, 1513, 9001, 9002, 10106, 10901; HCERA §§1003, 1401

Small Employers §§1304, 1311, 1421, 1512, 10105

Annual Fee §§9010, 10905; HCERA §1406

Subsidies: Out-of-Pocket Expenses §§1402, 1412; HCERA §1001

"Cadillac Plans" Tax §§9001, 10901; HCERA §1401

Health Insurance Policy Holder §§1001, 10101

Individual Mandate: Buy Health Insurance §§1501, 10106; HCERA §§1002, 1004

Large Business Employees §1511, 1512

Small Business Health Insurance Tax Credit §§1421, 10106

Health Savings Accounts §§9003, 9004

Small Business Employees §1512

Premium Tax Credit Subsidies §§1401, 1412, 10105; HCERA §§1001, 1004

"Excessive Profits" §§1001, 10101

Misuse of HSA Funds §9004

3.8% Investment Income Tax HCERA §1402

Individuals Mandates, Regulations, & Taxes §§1311, 1411, 1501, 9003-9005, 9013, 9015, 9017, 10106, 10902, 10906, 10907; HCERA §§1002, 1004, 1402, 1403

10% Tax On Indoor Tanning Services: §§9017, 10907

HSA Use Restriction §9003

Medicare Payroll Tax Increase: 0.9% §§9015, 10906; HCERA §1402

Flexible Spending Arrangement §§9005, 10902; HCERA §1403

Medicare Beneficiaries §3311

FSA Contribution Limit: $2,500 §§9005, 10902; HCERA§1403

Patients

Only Medical Expenses Above 10% of Income (AGI) are Tax Deductible §9013

Loan Repayment & Forgiveness Programs 4

Center for Medicare & Medicaid Innovation §§3021, 10305, 10306

Community-Based Care Transitions Program §3026

CMS §§3013, 3021, 3026, 3403, 10305, 10306, 10320

CMS Actuary §§1331, 3403, 10104

Federal Coordinated Health Care Office §2602

Medicaid/ CHIP Title II; §§1413, 3011

Medicaid Health Home Program §2703

State Medicaid Agencies §§2602, 2701, 2703, 3011

Medicaid Expansion: +16 million §§2001-2004 CBO Cost Estimate, 3/20/10

Medicare Cuts: $528.9bn (includes MA cuts) Title II; CBO Cost Estimate, 3/20/10

Medicare Advantage Cuts: $205.9bn §§3201, 10318; HCERA §1102; CBO Cost Estimate, 3/20/10

Subsidy: Medicare Part D Drug Program "Donut Hole" §3301; HCERA §1101

State-Specific Adult Health Quality Measures §2701

Medicaid Quality Measurement Program §2701

Medicare Title III, §2602

Non-Hospital Value-Based Purchasing Program §§3006, 10301

FFS Accountable Care Organizations Program §§3022, 10307

Demonstration Program §3001

Public Data Disclosure System §§3006, 10301

Hospital Value-Based Purchasing Program §§3001, 10333

Hospital Compare Website §3001

Hospitals §§1311, 3001, 10335

Medicare Administrative Contractors §3311

Physician Quality Reporting System §§3002, 10327, 10331

Physician Value-Based Payment Modifier §§3007

Hospital Quality Reporting Program §§3004, 3005

Medicare Prescription Drug and MA-PD Complaint System §3311

Medical Device Excise Tax §§9009, 10904; HCERA §1405

Home Health Agencies §3006

Ambulatory Surgical Centers §§3006, 10301

Skilled Nursing Facilities §§3006, 10310

Medical Device Manufacturers §§9009, 10904; HCERA §1405

Pharmaceutical Companies §9008; HCERA §1404

Annual Fee §9008; HCERA §1404

Health Industry Mandates, Regulations, Taxes, & Payment Cuts §§1311, 3001-3006, 3311, 9008, 9009, 10327, 10331, 10335, 10904; HCERA §§1404, 1405

Hospice Programs §3004

Inpatient Rehabilitation Facilities §3004

Long-Term Care Hospitals §3004

PPS-Exempt Cancer Hospitals §3005

Physicians §§1311, 3002, 3003, 10327, 10331

New Government

- Rationing Potential
- Involvement in Health Insurance Market
- Other Expansions
- Represents Bundles of Additional Entities
- Mandates
- Taxes & Monetary Fees/ Penalties/Cuts
- Trust Fund (Rationing Potential)
- Other New Trust Funds/ Monetary Benefits

Expanded Government

- Government with Expanded Authority/ Responsibility
- Government Financial Entity with New Inflows/ Outflows
- State/Territory with Expanded Authority/ Responsibility

Private

- Private Entity with New Mandates/ Regulations/ Responsibilities
- Unchanged Private Entity
- Special Interest Provisions

New Relationships

- Regulations/ Requirements/Mandates
- Reporting Requirements
- Oversight
- Money Flows
- Consultation/Advisory/ Info Sharing
- Structural Connections (Includes Existing)

AGI: Adjusted Gross Income
AHRQ: Agency for Healthcare Research and Quality
CDC: Centers for Disease Control & Prevention
CHIP: Children's Health Insurance Program
CLASS: Community Living Assistance Services & Supports
CMS: Centers for Medicare & Medicaid Services
CO-OP: Consumer Operated & Oriented Program
FFS: Fee-for-Service
FSA: Flexible Spending Arrangement
GAO: Government Accountability Office
HCERA: Health Care & Education Reconciliation Act
HHS: Health & Human Services Department
HSA: Health Savings Account
IPAB: Independent Payment Advisory Board
IRS: Internal Revenue Service
MA-PD: Medicare Advantage Prescription Drug
MedPAC: Medicare Payment Advisory Commission
MERD: Medical Early Risk Detection
EALORS: Executive Auxiliary Linked Office Regional Systems
MEWA: Multiple Employer Welfare Arrangement
NAIC: National Association of Insurance Commissioners
NIH: National Institutes of Health
PCORI: Patient-Centered Outcomes Research Institute
PPS: Prospective Payment System

Patient Protection & Affordable Care Act, P.L. 111-148; Health Care & Education Reconciliation Act, P.L. 111-152

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