No. 135, Original

In the Supreme Court of the United States

STATE OF TEXAS, ET AL., PLAINTIFFS

v.

MICHAEL O. LEAVITT, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON MOTION FOR LEAVE TO FILE BILL OF COMPLAINT AND MOTION FOR A PRELIMINARY INJUNCTION

BRIEF FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES IN OPPOSITION

PAUL D. CLEMENT
Solicitor General
Counsel of Record

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

JEFFREY P. MINEAR
Assistant to the Solicitor General
MARK B. STERN
ALISA B. KLEIN
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

QUESTION PRESENTED

Section 103 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2155 (to be codified at 42 U.S.C. 1396u-5(c)), adjusts the federal funding that States receive under the Medicaid program, 42 U.S.C. 1396 *et seq.*, to account for the savings that States realize through the MMA's provision of a prescription drug benefit to Medicaid recipients who are eligible for Medicare. The question presented is whether that adjustment is a valid exercise of Congress's power under the Spending Clause and the Necessary and Proper Clause of the Constitution.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Cases—Continued: Page

Cases—Continued: Page

Constitution, statutes and regulation:

Statutes and regulation—Continued: Page

In the Supreme Court of the United States

No. 135, Original

STATE OF TEXAS, ET AL., PLAINTIFFS

v.

MICHAEL O. LEAVITT, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON MOTION FOR LEAVE TO FILE BILL OF COMPLAINT AND MOTION FOR A PRELIMINARY INJUNCTION

BRIEF FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES IN OPPOSITION

JURISDICTION

The plaintiff States invoke this Court's original jurisdiction under Article III, Section 2, of the United States Constitution and 28 U.S.C. 1251(b)(3). See Mot. for Leave to File Bill of Compl. (Compl. Mot.) 1; Bill of Compl. para. 2; see also *South Carolina* v. *Katzenbach*, 383 U.S. 301, 307 (1966).

STATEMENT

A. Introduction

The plaintiff States seek leave to file a bill of complaint challenging the constitutionality of provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2066. The provisions at issue, contained in Section 103(c), 117 Stat. 2155, govern the financing of

prescription drug coverage for persons, known as dually eligible individuals (dual eligibles), who qualify for health care benefits under both the Medicare provisions and the Medicaid provisions of the Social Security Act. See 42 U.S.C. 1395 *et seq.* (Medicare); 42 U.S.C. 1396 *et seq.* (Medicaid). Section 103(c) of the MMA, which will be codified at 42 U.S.C. 1396u-5(c) and is therefore referred to herein as Section 1396u-5(c), directs that a State receiving federal funding for its Medicaid program must return a small percentage of those funds based on an approximation of the savings that the State realizes through the MMA's provision of a Medicare-based prescription drug benefit to the dual eligibles covered by that State's Medicaid program. See 42 U.S.C. 1396u-5(c)(1)(B).

Congress enacted Section 1396u-5(c) in December 2003, with a delayed effective date of January 1, 2006. Its repayment requirement, 42 U.S.C. 1396u-5(c)(1)(B), is merely an accounting mechanism for adjusting federal funding of state Medicaid programs to reflect the savings that the States realize through the MMA's creation of a Medicare prescription drug benefit that is available to certain of their Medicaid recipients. Section 1396u-5(c) applies only to States that choose to participate in the Medicaid program, and its provisions are functionally identical to other longstanding Medicare provisions that make adjustments to federal funding of state Medicaid programs to account for increased Medicare coverage for dual eligibles. See 42 U.S.C. 1395v, 1396d(a), 1396d(p)(3). Section 1396u-5(c) directs the States to make a payment into the Medicare Prescription Drug Account, which funds the prescription drug benefit. See 42 U.S.C. 1396u-5(c)(1)(B). But if a State fails to make its payment, the only consequence is that the amount owed plus interest will be offset

against amounts otherwise payable to the State under the Medicaid program. See 42 U.S.C. 1396u-5(c)(1)(C).

The plaintiff States nevertheless contend that Section 1396u-5(c) should be regarded as a direct tax on the States that contravenes the doctrine of intergovernmental tax immunity (Compl. Mot. 5-9), the States' ability to govern (*id.* at 11-16), the anti-commandeering principle (*id.* at 16-18), and the Guarantee Clause (*id.* at 19-20). They argue that this Court should exercise its original jurisdiction because their challenge has nationwide importance and litigation in the lower courts would entail undue delay. *Id.* at 20-28. They have separately moved for a preliminary injunction, asking this Court to enjoin enforcement of any of the provisions of Section 1396u-5(c) pending the resolution of the matters set forth in the bill of complaint. Mot. for Prelim. Inj. 4-11. This brief responds to, and opposes, both motions.

B. Statutory Background

1. The Medicare program

Title XVIII of the Social Security Act, known as the Medicare Act, establishes a program of federally subsidized health insurance for approximately 41 million Americans. 42 U.S.C. 1395 *et seq.* About 35 million Medicare beneficiaries are seniors over the age of 65. H.R. Rep. No. 810, 108th Cong., 1st Sess. 123 (2005). About 6 million Medicare beneficiaries are individuals with disabilities under the age of 65. *Ibid.*

The Medicare Act is divided into four parts. Part A is a mandatory program that covers hospital inpatient and related care. Qualifying individuals—seniors or disabled persons who meet certain eligibility requirements—are automatically enrolled in Part A. See 42 U.S.C. 1395c, 1395d. Part B is a voluntary program

that provides Part A enrollees who elect to pay a monthly premium and deductible with supplemental coverage for hospital outpatient services, physician services, and other items and services not covered under Part A. See 42 U.S.C. 1395j, 1395k, 1395*l*, 1395*o*, 1395x(s). Part C offers, as an alternative to the traditional fee-for-service coverage available through Parts A and B, a managed-care package known as Medicare Advantage (formerly called Medicare+ Choice). 42 U.S.C. 1395w-21(a)(1). Part D, which was created by Title I of the MMA and became effective on January 1, 2006, provides supplemental Medicare coverage for the cost of prescription drugs through voluntary enrollment in drug plans offered by private sponsors. See §§ 101-111, 117 Stat. 2071-2176 (to be codified at 42 U.S.C. 1395w-101 *et seq.*). Part D, which for the first time established a comprehensive program for Medicare coverage of prescription drugs, has been described as "the most significant change to the Medicare program since its inception in 1965." 70 Fed. Reg. 4197 (2005).

2. The Medicaid program

Title XIX of the Social Security Act, known as the Medicaid Act, establishes a separate federal-state program that provides medical assistance for low-income persons. 42 U.S.C. 1396 *et seq.* The Medicaid program provides federal financial assistance, in the form of federal matching funds, to States that elect to pay for medical services on behalf of certain needy individuals. See *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). Federal financial participation is calculated according to a statutory formula that pays between 50% and 83% of a State's costs. 42 U.S.C. 1396b(a)(1), 1396d(b); see

Arkansas Dep't of Health & Human Servs. v. *Ahlborn*, No. 04-1506 (May 1, 2006), slip op. 4.

State participation in the Medicaid program is optional, but once a State elects to participate, it must comply with the requirements of the Medicaid Act. See *Ahlborn*, slip op. 4; *Harris*, 448 U.S. at 301. In order to participate in the Medicaid program, a State must have a plan for medical assistance approved by the Secretary of Health and Human Services. 42 U.S.C. 1396a(b); see *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 650 (2003). A state plan must provide coverage for specified categories of individuals, known as "mandatory" populations, and may provide coverage for other categories of individuals, known as "optional" populations. See *id.* at 650-651 & nn.4-5. In addition, for purposes of the mandatory populations, the plan must provide coverage for certain types of services, such as inpatient and outpatient hospital services. See 42 U.S.C. 1396a(a)(10)(A), 1396d(a)(1) and (2)(A). The plan may provide coverage for other specified types of services, such as dental services. See 42 U.S.C. 1396d(a)(10).

The Medicaid program allows, but does not require, participating States to provide coverage of prescription drugs under their state plans. See 42 U.S.C. 1396d(a)(12). At the time that the MMA became effective, on January 1, 2006, all 50 States and the District of Columbia had chosen to cover prescription drugs for at least some Medicaid enrollees. See Bill of Compl. para. 9.

3. The Medicare buy-in program for dual eligibles

The Medicaid program overlaps with the Medicare program in the case of needy persons who are also over 65 or have disabilities. Approximately 6 million persons

who qualify for full Medicaid benefits also qualify for Medicare by virtue of their age or disability. S. Rep. No. 229, 106th Cong., 2d Sess., Pt. 2, at 1256 (2000). A person who qualifies for coverage under both programs is known as a "full-benefit dual eligible individual," 42 U.S.C. 1396u-5(c)(6), or simply a "dual eligible." Although those individuals are often eligible to participate in Medicare Part B, they may be unable to afford the premiums needed to enroll, or the coinsurance, copayments, and deductibles for which they would be responsible, under the Part B program.

If those dual eligibles were not enrolled in Medicare Part B, state Medicaid programs would be faced with bearing the full cost of medical services that Medicare Part B would cover, contrary to the general principle that Medicaid is to be the payor of last resort. See, *e.g.*, *Connecticut Dep't of Soc. Servs.* v. *Leavitt*, 428 F.3d 138, 141-142 (2d Cir. 2005). To address that situation, Congress has encouraged States participating in the Medicaid program to make the Part B option available to qualified Medicaid recipients. See 42 U.S.C. 1396b(b)(1). The States have typically done so through "buy-in" agreements with the Secretary. See 42 U.S.C. 1395v, 1396d(a), 1396d(p)(3)(A).[1]

Under a buy-in agreement, a State uses Medicaid funds to pay Medicare Part B premiums on behalf of

---

[1] Congress made participation by the States in the buy-in program optional when it created the program in 1965, but it gave the States a strong additional incentive to participate in 1967, when it amended the Medicaid Act to deny federal matching funds to a state Medicaid program for any costs that could have been avoided if dual eligibles had been enrolled in Medicare Part B. See Social Security Amendments of 1967, Pub. L. No. 90-248, Tit. II, Pt. 2, § 222(c), 81 Stat. 901 (codified as amended at 42 U.S.C. 1396b(b)(1)).

individuals who are eligible for both Medicare and Medicaid, and those individuals are then enrolled in Medicare Part B. See 42 U.S.C. 1395v, 1396d(a), 1396d(p)(3)(A), 1396a(a)(10)(E)(i). Once a dual eligible is enrolled in Medicare Part B, the state Medicaid program is required to pay Medicare copayments and deductibles on the qualifying dual eligible's behalf. 42 U.S.C. 1396a(a)(10)(E)(i), 1396d(p)(3)(B)-(D). As a result of the buy-in, the cost of the dual eligible's medical care is largely shifted from the State (with federal assistance) under the Medicaid program to the federal government under Medicare.[2]

The Part B premiums paid by a State participating in a buy-in agreement are deposited in the Federal Supplementary Medical Insurance Trust Fund of the Treasury, the Medicare Part B Trust Fund. 42 U.S.C. 1395v; 42 U.S.C. 1395s(f).

4. The MMA's provisions for financing the cost of prescription drugs for dual eligibles

Medicare Part D has special provisions for dual eligible Medicaid recipients that are similar in structure and purpose to those that have long addressed dual eligibles under Medicare Part B. Congress has provided that dual eligibles will automatically receive the Medicare Part D drug benefit, unless an individual has coverage through an employer-based prescription drug plan, and they are entitled to have premiums and deductibles paid for them by the federal government. 117 Stat. 2107-2110 (to be codified at 42 U.S.C. 1395w-

---

[2] The state Medicaid program remains responsible for paying the cost of medical services provided to the dual eligible, to the extent that the services are covered by Medicaid but not Medicare. See 42 U.S.C. 1396a(a)(8) and (10)(A).

114(a)(1)(A), (a)(3)(B)(v)(I)); see 70 Fed. Reg. 4194, 4196, 4421 (2005). But Congress has adjusted the federal contribution to each State's Medicaid program, based on a prescribed formula, to reflect the federal government's assumption of costs that would otherwise be borne by the States through their Medicaid programs. See 42 U.S.C. 1396u-5(c).

Section 1396u-5(c) makes that adjustment by directing States to return funds, by monthly direct payment, to the Medicare Prescription Drug Account. 42 U.S.C. 1396u-5(c)(1)(B). The amount of the payment is calculated under a statutory formula that estimates the savings that each State will realize from no longer providing prescription drug coverage for dual eligibles under its state Medicaid program. See 42 U.S.C. 1396u-5(c)(2)-(5). The calculated amount is based on a percentage of the State's anticipated savings. That percentage, known as the phased-down percentage, is 90% of a State's 2006 anticipated savings, but the percentage gradually declines to 75% in 2015 and years after. See 42 U.S.C. 1396u-5(c)(5).

Section 1396u-5(c) explicitly provides that each State's monthly payment "shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under [a buy-in agreement for dual eligibles], except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund." 42 U.S.C. 1396u-5(c)(1)(B). Thus, Section 1396u-5(c) establishes essentially the same procedure for state payment as is employed in the case of Medicare Part B buy-in agreements, except that the state payments are deposited into a special prescription drug account within the Medicare Trust Fund. See 42 C.F.R. 423.910(b)(2).

Section 1396u-5(c) also specifies the consequence of a State's failure to pay. If a State fails to pay the required amount, the only consequence is that the amount owed, with interest, will be offset against amounts otherwise payable to the State under the Medicaid program. 42 U.S.C. 1396u-5(c)(1)(C).

C. The Plaintiff States' Claims

The plaintiff States seek leave to file a bill of complaint challenging the constitutionality of the MMA's provisions for adjusting the amount of the federal contribution to state Medicaid programs to take account of the savings that the States realize from the federal government's provision of a prescription drug benefit to dual eligibles. See 42 U.S.C. 1396u-5(c). The States object, in particular, to Section 1396u-5(c)'s provision for making that adjustment through a state payment to the federal government, even though the States have been following a similar practice for nearly 40 years to account for the cost savings associated with coverage of dual eligibles under Medicare Part B. See p. 5-7, *supra*.

The States characterize Section 1396u-5(c) as "direct taxation of the States." Compl. Mot. 5. Relying on that characterization, the States argue that the MMA provisions: (1) constitute an unconstitutional intergovernmental tax (*id.* at 5-16); (2) impermissibly commandeer the States' appropriations processes (*id.* at 16-19); and (3) deny the States a "Republican Form of Government" by usurping state governmental processes (*id.* at 19-20 (quoting U.S. Const. Art. IV, § 4)).

The States further contend that the Court should exercise its non-exclusive original jurisdiction in this case because: (1) they raise claims of "great constitutional importance" (Compl. Mot. 21-23); (2) they have

no adequate alternative forum for prompt resolution of their claims (*id.* at 23-25); and (3) their claims are justiciable (*id.* at 25-28). The States seek, in their bill of complaint, an order permanently enjoining the enforcement of 42 U.S.C. 1396u-5(c). See Bill of Compl., prayer for relief, para. 3. The States have separately moved for a preliminary injunction, urging this Court to enjoin enforcement of 42 U.S.C. 1396u-5(c) pending the resolution of the matters set forth in the bill of complaint. Mot. for Prelim. Inj. 4-11.

ARGUMENT

THE MOTIONS FOR LEAVE TO FILE A BILL OF COMPLAINT AND FOR A PRELIMINARY INJUNCTION SHOULD BE DENIED

A. This Case Does Not Fall Within The Narrow Class Of Disputes That Warrant This Court's Exercise Of Its Non-Exclusive Original Jurisdiction

Article III of the Constitution provides that this Court shall have original jurisdiction over a limited class of disputes, including those "in which a State shall be Party." U.S. Const. Art. III, § 2. Congress has further specified that the Court "shall have original and exclusive jurisdiction" only over those controversies between two or more States. 28 U.S.C. 1251(a). Congress has determined that the Court shall have "original but not exclusive jurisdiction" over actions "by a State against the citizens of another State," 28 U.S.C. 1251(b), which this Court has determined to include actions by one or more States against a federal official who is not a citizen of a plaintiff State. See *South Carolina* v. *Katzenbach*, 383 U.S. 301, 307 (1966).

This Court therefore has the power to exercise jurisdiction over the plaintiff States' claims, but it is under

no obligation to do so. The Court has consistently recognized that, even in the instance of cases (unlike this one) that fall within its exclusive original jurisdiction, it has discretion to decline to exercise that jurisdiction. See, *e.g.*, *Mississippi* v. *Louisiana*, 506 U.S. 73, 76 (1992); *Wyoming* v. *Oklahoma*, 502 U.S. 437, 450 (1992). The Court does not routinely take jurisdiction of original actions. Rather it exercises its discretion "with an eye to promoting the most effective functioning of th[e] Court within the overall federal system." *Ibid.* (quoting *Texas* v. *New Mexico*, 462 U.S. 554, 570 (1983)). The Court has repeatedly emphasized that, in the sphere of its non-exclusive jurisdiction, the Court's power to act as the tribunal of *first and last resort* "should be invoked sparingly." *Illinois* v. *City of Milwaukee*, 406 U.S. 91, 93 (1972) (quoting *Utah* v. *United States*, 394 U.S. 89, 95 (1969)); see, *e.g.*, *Washington* v. *General Motors Corp.*, 406 U.S. 109, 113 (1972); *Ohio* v. *Wyandotte Chems. Corp.*, 401 U.S. 493, 500-501 (1971).

The Court accordingly exercises its original jurisdiction only in "appropriate cases." *Wyoming* v. *Oklahoma*, 502 U.S. at 451 (quoting *Illinois*, 406 U.S. at 93-94). The Court has further explained:

> [T]he question of what is appropriate concerns, of course, the seriousness and dignity of the claim; yet beyond that it necessarily involves the availability of another forum where there is jurisdiction over the named parties, where the issues tendered may be litigated, and where appropriate relief may be had.

Ibid. Accord *California* v. *Texas*, 457 U.S. 164, 168 (1982); see *ibid.* ("We incline to a sparing use of our original jurisdiction so that our increasing duties with

the appellate docket will not suffer") (quoting *Illinois*, 406 U.S. at 93-94).

A State that seeks to challenge the constitutionality of federal action normally faces an especially heavy burden in establishing that the challenge is "appropriate" for this Court's exercise of its non-exclusive jurisdiction. First, this Court "begin[s] with the time-honored presumption" that Congress, in enacting federal legislation, acts within constitutional bounds, *Reno* v. *Condon*, 528 U.S. 141, 148 (2000), and that Executive Branch officers, in implementing those laws, "properly discharge[] their official duties," *United States* v. *Chemical Found., Inc.*, 272 U.S. 1, 15 (1926). Second, a State almost invariably has a readily available alternative forum—a federal district court—that is fully capable of adjudicating constitutional issues and rendering decisions that will be subject to this Court's ultimate review. See 28 U.S.C. 1331. As a result of those considerations, this Court typically has summarily declined to exercise jurisdiction over such suits.[3] The Court has accepted jurisdiction over only a handful of such cases in the past 40 years, and those cases have arisen in circumstances that are very different from

---

[3] See, *e.g.*, *Michigan* v. *Meese*, 479 U.S. 1078 (1987) (challenge to the constitutionality of applying the federal wiretapping statute, 18 U.S.C. 2515, in state judicial proceedings); *Idaho* v. *Vance*, 434 U.S. 1031 (1978) (challenge to the constitutionality of the disposal of United States property interests in the Panama Canal); *Georgia* v. *Nixon*, 414 U.S. 810 (1973) (challenge to federal impounding of federal financial assistance to States); *Alabama* v. *Connally*, 404 U.S. 933 (1971) (challenge to tax exemptions for certain charities); *Massachusetts* v. *Laird*, 400 U.S. 886 (1970) (challenge to federal involvement in the Indochina war); *Mississippi* v. *Finch*, 396 U.S. 553 (1970) (challenge to federal school desegregation efforts in Mississippi).

those presented here. See *South Carolina* v. *Regan*, 465 U.S. 367 (1984); *Oregon* v. *Mitchell*, 400 U.S. 112 (1970); *South Carolina* v. *Katzenbach*, 383 U.S. 301 (1966).[4]

---

[4] In *South Carolina* v. *Regan*, the Court granted leave to file a complaint (after full briefing and oral argument) to consider a state challenge to a federal statute restricting a federal tax deduction for interest income earned on state-issued bonds. See 465 U.S. at 370-373. In that case, however, the State did not have a readily available forum in which to challenge the validity of the tax and the statute was believed to have a material adverse impact on the State. *Id.* at 373, 381; *id.* at 381-382 (plurality opinion); *id.* at 401-402 (O'Connor, J., concurring in the judgment). Here the plaintiff States have a readily available alternative forum, and the MMA operates to the financial advantage of the States. Furthermore, in *South Carolina*, the State founded its claim for relief on a controlling decision of the Court, *Pollock* v. *Farmers' Loan & Trust Co.*, 157 U.S. 429 (1895), that had been called into question by subsequent decisions. See 465 U.S. at 372; *id.* at 404- 417 (Stevens, J., dissenting). Justice Stevens warned that the Court would "do South Carolina no favor by permitting it to file and litigate a claim on which it has no chance of prevailing." *Id.* at 419. Nevertheless, the Court had an understandable reason to address the State's claims in the first instance—the lower courts would be bound by *Pollock*. Four years later—after extensive proceedings before a Special Master—the Court overruled *Pollock* and, as Justice Stevens predicted, entered judgment for the federal respondent. See *South Carolina* v. *Baker*, 485 U.S. 505 (1988). In this case, by contrast, there is no similar obstacle to prevent the lower courts from correctly resolving the States' claims. See pp. 23-26, *infra*.

South Carolina v. *Katzenbach* involved constitutional challenges to the Voting Rights Act of 1965, Pub. L. No. 89-110, 79 Stat. 437 (383 U.S. at 307), while *Oregon* v. *Mitchell* and its companion cases involved constitutional challenges to the Voting Rights Act Amendments of 1970, Pub. L. No. 91-285, 84 Stat. 314 (400 U.S. at 117). In each of those cases, the federal government *supported* the Court's expedited exercise of its original jurisdiction in light of impending state elections that would be substantially affected by the new laws. See *Oregon* v. *Mitchell*, No. 43 (October

The plaintiff States in this case cannot persuasively invoke the Court's exercise of its non-exclusive original jurisdiction because, by any standard, their complaint does not set out an "appropriate case." First, the States' facial constitutional challenge to the relevant provisions of the MMA, which merely reduce federal funding of state Medicaid programs to reflect the savings that the States realize through the MMA's provision of a federal prescription drug benefit, is insubstantial. Second, the States have familiar, efficient, and cost-effective alternative fora—the federal district courts—that are far preferable, as a practical matter, for resolving any State challenges to the MMA's adjustment of federal Medicaid funding.

1. The States' constitutional claims are not substantial

a. The plaintiff States premise their bill of complaint on the assertion that the MMA's adjustment to federal funding for state Medicaid programs should be viewed as a direct tax on the States. See Bill of Compl. paras. 18-19; Compl. Mot. 5-16. That characterization, however, misstates the substance and effect of the relevant statutory provision, Section 1396u-5(c). Congress has simply required, as a reasonable and valid condition on its generous grant of federal funding for state Medicaid

---

1970), Mem. for the Def. at 2-3; *South Carolina* v. *Katzenbach*, No. 22 (October 1965), Mem. for the Def. at 1-3. Moreover, those cases arose before the Court's more precise articulation, in *Illinois* v. *City of Milwaukee*, *supra*, of standards for determining what cases are "appropriate" for this Court's exercise of original jurisdiction. Since that time, this Court has addressed constitutional challenges to the Voting Rights Act, like constitutional challenges generally, through the exercise of its appellate or certiorari jurisdiction. See, *e.g.*, *Mississippi Republicans Executive Comm.* v. *Brooks*, 469 U.S. 1002 (1984); *City of Rome* v. *United States*, 446 U.S. 156 (1980); see also, *e.g.*, *Tennessee* v. *Lane*, 541 U.S. 509 (2004).

programs, that States return a portion of the savings that they realize from Congress's provision of a prescription drug benefit to their Medicare-eligible Medicaid recipients. See 42 U.S.C. 1396u-5(c).

The States assert that Section 1396u-5(c) "operates as a discriminatory tax" that requires the States to "raise, allocate, and remit to the federal government state monies to fund an exclusively federal program." Compl. Mot. 5-6. That characterization overlooks the actual operation of Section 1396u-5(c), which is but one provision of an integrated federal funding scheme for medical services under two titles of the Social Security Act. Title XIX of the Social Security Act (Medicaid Act) provides massive federal funding—approximately $190 billion in aggregate for fiscal year 2006—for state Medicaid programs. See Congressional Budget Office, *Current Budget Projections* 4 (Mar. 3, 2006) <http://www.cbo.gov/budget/budproj.pdf>. Section 1396u-5(c) merely makes a relatively small adjustment in federal funding for state Medicaid programs to take account of the fact that Congress's expansion of a related federally funded program—Title XVIII of the Social Security Act (Medicare)—will necessarily result in cost savings for state Medicaid programs. Congress's modest reduction in the amount of funding it gives a State to run a federally-subsidized program to reflect the State's reduced program costs—cost savings that arise from Congress's expansion of an overlapping federal entitlement program—cannot sensibly be considered a "tax."[5]

---

[5] The Section 1396u-5(c) adjustment is, of course, dwarfed by the federal government's overall contribution to the funding of state Medicaid programs. HHS estimates that the Section 1396u-5(c) adjustment for calendar year 2006 will be less than 5% of the federal funds that the plaintiff States will receive for their state

The States' characterization of Section 1396u-5(c) as imposing a "tax" is especially strained in light of how Congress has calculated the reduction in federal funding. Section 1396u-5(c) adjusts the federal contribution to state Medicaid programs to reflect the fact that the MMA relieves the States of the responsibility that they previously had to contribute to the cost of providing prescription drug benefits to individuals who are, by definition, Medicaid-eligible. As the States recognize (Compl. Mot. 2), the adjustment is calculated by means of a formula that estimates the savings that States are expected to realize from the federal government's provision of prescription drug coverage for dual eligibles through expansion of the Medicare program. See 42 U.S.C. 1396u-5(c). Moreover, that adjustment, which is just one of many interrelated limitations that Congress has placed on its provision of federal funding for Medicaid, allows the States to retain a portion of their projected total savings, increasing from 10% in 2006 to 25% in 2015. See 42 U.S.C. 1396u-5(c)(5). A financial arrangement that is designed to result in a net *savings* for the States under a program that is infused with massive federal support and subject to ongoing financial adjustments, cannot sensibly be considered a "tax" that implicates questions of "intergovernmental tax immunity" (Compl. Mot. 6-14).[6]

Medicaid programs. See Decl. of John D. Klemm (May 15, 2006), App., 1a-4a, *infra*.

[6] The States' discussion (Compl. Mot. 6-9) of the history of intergovernmental tax immunity is accordingly inapposite. Similarly inapposite is the States' discussion (*id.* at 9-11) of *Massachusetts* v. *United States*, 435 U.S. 444 (1978), which held—far afield from the issues here—that Congress may subject state-owned aircraft to a nondiscriminatory annual registration fee on civil aircraft that fly in United States airspace. See *id.* at 446, 467-470. Indeed, the

The State's policy concern that the Section 1396u-5(c) adjustment could result in state budgetary uncertainty (Compl. Mot. 11-14) says nothing about whether the adjustment is a tax. States have no constitutional claim to certainty as to the amount of net federal funds that they will receive to support their Medicaid programs in a given year. Congress may always elect to reduce Medicaid funding, and if the States find that uncertainty objectionable, they are free to decline receipt of any Medicaid funds at all. In any event, the plaintiff States' contentions about budgetary uncertainty are greatly overstated, since the amount of a State's payments is calculated pursuant to a specific statutory formula based on that State's own per capita prescription drug expenditures in 2003. See p. 8, *supra*. To the extent some uncertainty in the total amount may be attributable to uncertainty about the number of dual eligibles the State will have at any particular time, that is no different than the sort of uncertainties States routinely face in the administration of their Medicaid programs. And while the plaintiff States contend (Compl. Mot. 12-13) that calculations respecting their payments for 2006 have been revised several times, such modifications are to be expected in the institution of a new program like this one.

b. The States acknowledge (Compl. Mot. 14-16) that Congress may impose limitations and conditions on federal funding as a valid exercise of power under the Spending Clause, U.S. Const. Art. I, § 8, Cl. 1, and the Necessary and Proper Clause, *id.* Art. I, § 8, Cl. 18. See, *e.g.*, *South Dakota* v. *Dole*, 483 U.S. 203 (1987). The Court reaffirmed in *South Dakota* that "Congress

---

States concede (Compl. Mot. 10) that their concerns are directed at dicta therein.

may attach conditions on the receipt of federal funds, and has repeatedly employed the power 'to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives.'" *Id.* at 206 (citations omitted). The States nevertheless argue (Compl. Mot. 14-16) that Section 1396u-5(c) does not qualify as a valid condition because Congress did not expressly label it as such, and because Section 1396u-5(c) directs the States to "pay" back a certain amount of funds. Neither distinction is tenable.[7]

First, Congress is under no obligation to label each of the numerous federally-prescribed requirements for participation in the Medicaid program, set out throughout Title XIX of the Social Security Act, as a "condition" of federal funding. The question is whether the limitation at issue functions as a condition—*viz.*, whether Congress prescribed the limitation as a requirement for States that elect to participate in the program. See *South Dakota*, 483 U.S. at 205 (treating

---

[7] The States concede in a footnote (Compl. Mot. 15 n.10) that congressional conditions on federal funding are permissible if they (i) serve the "general welfare"; (ii) are "unambiguous"; (iii) are not "unrelated" to the spending program; and (iv) are not proscribed by other constitutional provisions. *South Dakota*, 483 U.S. at 207-208. The States contend (Compl. Mot. 15 n.10) that the Section 1396u-5(c) adjustment fails only the second requirement. They urge that Section 1396u-5(c) is not unambiguous because it employs a formula that requires use of factors that vary from year-to-year and from State-to-State. But the formula is itself certain, and it clearly allows the States, in determining whether to participate in the Medicaid program, "to exercise their choice knowingly, cognizant of the consequences of their participation." *South Dakota*, 483 U.S. at 207 (citation omitted). The States' claim that Section 1396u-5(c) is fatally ambiguous is accordingly without merit.

as a "condition" a statutory provision directing the Secretary of Transportation to withhold a percentage of highway funds from States "in which the purchase or public possession * * * of any alcoholic beverage by a person who is less than twenty-one years of age is lawful" (23 U.S.C. 158 (Supp. III 1985)). Section 1396u-5(c), which sets out the adjustment, plainly satisfies that test.[8]

Second, Congress is entitled to make an adjustment in federal funding through a statutory provision that requires the States to repay a modest portion of the total amount of federal funds they receive for their Medicaid programs to reflect the cost savings that they have simultaneously realized through Congress's provision of a prescription drug benefit. See 42 U.S.C. 1396u-5(c). Contrary to the States' suggestion (Compl.

---

[8] The States note (Compl. Mot. 14) that another subsection of the statute, Section 1396u-5(a), explicitly makes its requirements a "condition" on receipt of federal Medicaid funds. They argue that Section 1396u-5(c), which does not make use of the term "condition," should therefore not be considered as such. The States overlook, however, the key difference between Section 1396u-5(a) and (c) that explains the use of the term "condition" in one subsection but not the other. Section 1396u-5(a) requires the States to make certain eligibility determinations and to provide certain information about individuals who are *not* eligible for Medicaid. Congress made explicit reference to those requirements as "conditions" of Medicaid funding because, if it had not done so, States might argue that Congress did not intend that federally mandated actions concerning persons outside of the Medicaid program would be conditions on receipt of Medicaid funds. By contrast, Section 1396u-5(c) directly implicates the financing of prescription drug benefits for individuals who are Medicaid eligible, and there is no room for any doubt that Section 1396u-5(c)—which provides for a reduction of federal funding for a State's Medicaid program if a State does not comply with the payment requirement—sets out a condition for receipt of federal Medicaid funds.

Mot. 14), there is nothing unusual in such "payback" arrangements. The States have been making similar payments to the federal government since 1967 to provide the same "dual eligible" participants with Medicare Part B coverage through the "buy-in program." See pp. 5-7, *supra*. Under that 39-year-old buy-in program, the States pay Medicare Part B premiums to the federal government on behalf of dual eligibles, and those payments are deposited in the Medicare Trust Fund. Congress explicitly followed the same familiar approach in providing the same dual eligible population with a Medicare prescription drug benefit, except that the States' payments are deposited into a special account within the Medicare Part B Trust Fund that is used specifically for that benefit. See 42 U.S.C. 1396u-5(c)(1)(B).[9]

---

[9] There is no merit to the States' suggestion that a federal condition on receipt of federal funds cannot take the form of a requirement that a State "*pay* a certain amount of funds" (Compl. Mot. 14). The federal Medicaid program is predicated on a wide variety of federal provisions that direct States to make payments as a condition for receiving federal funds. For example, once a State chooses to participate in the Medicaid program, the Medicaid Act makes coverage of various populations and various services mandatory. See, *e.g.*, 42 U.S.C. 1396a(a)(10)(A)(i). Even optional populations and services must be covered if a State chooses to include them in its state plan. See, *e.g.*, 42 U.S.C. 1396a(a)(8). Thus, participating States are required to make a wide range of payments to hospitals, physicians, and other providers.

It is also irrelevant that Congress has directed that the State payments to the federal government are deposited in an account "to fund *Medicare*" (Compl. Mot. 15). In the MMA, Congress has simply required participating States to make payments to the entity that provides for the coverage of prescription drugs, which happens to be the federal government under Medicare Part D, working through private insurers. Congress has quite rationally directed that the States' payments, which reflect the States'

In short, there is no merit to the States' contention that Section 1396u-5(c) is an unconstitutional tax; rather, it is a valid, reasonable, and unexceptional statutory condition on the receipt of federal funds. Here, as in *South Dakota*, if the State finds Section 1396u-5(c)'s imposition of a modest adjustment in the federal government's funding of state Medicaid benefits unacceptable, it can avoid the condition by declining to accept the federal government's generous funding of state Medicaid programs. It is unclear, however, why any State would choose to do so. The MMA's provision of a Medicare prescription drug benefit should result in cost savings for state Medicaid programs, and Section 1396u-5(c)'s "phased-down" adjustment is structured to recapture only a percentage (beginning at 90% and decreasing to 75%) of that projected savings. See 42 U.S.C. 1396u-5(c)(5). Far from being a tax, Congress structured Section 1396u-5(c) to provide a *net financial benefit* for the States.

c. The States' remaining claims—that Congress has "commandeered" state appropriations processes in violation of the Tenth Amendment (Compl. Mot. 16-19) and denied the States a "Republican Form of Government" in violation of Article IV, Section 4, of the Constitution (Compl. Mot. 19-20)—are not substantial.

---

savings on account of Congress's extension of a Medicare prescription drug benefit to the States' Medicare-eligible, Medicaid recipients, should be applied directly to funding the Medicare prescription drug benefit. And of course, the State need not even make that payment. If a State fails to make the prescribed payment, the only consequence is that the Secretary will offset the amount owed plus interest against the federal funds otherwise payable to the State under the Medicaid program. See 42 U.S.C. 1396u-5(c)(1)(B).

The States assert that Congress has "conscript[ed] state governments as its agents" (Compl. Mot. 17, citing *New York* v. *United States*, 505 U.S. 144, 178 (1992)), and impaired the power of each State "to order the processes of its own governance" (*id.* at 20, quoting *Alden* v. *Maine*, 527 U.S. 706, 752 (1999)). But that is surely not true. Congress has simply adjusted its provision of federal funding for state Medicaid programs to reflect the cost savings that States realize from Congress's provision of a Medicare prescription drug benefit. Understood in its appropriate context, Section 1396u-5(c) is little more than an accounting feature of the MMA and the Medicaid program, and Congress is under no obligation to follow a "particular form of accounting." See *New York* v. *United States*, 505 U.S. at 172. Congress has directed the States to remit a percentage of the cost savings to the federal government, but even the slight burden of making a payment is optional. If States do not wish to remit the prescribed portion of their cost savings, see 42 U.S.C. 1396u-5(c)(1)(A), they need do nothing, and the Secretary will make the prescribed adjustment (with interest) when providing subsequent federal funding for the State's Medicaid program, see 42 U.S.C. 1396u-5(c)(1)(B). Alternatively, the States can choose not to participate in the Medicaid program, in which case they will not be subject to any remittance or offset requirement.

Congress has neither required nor prohibited any state action apart from compliance with the requirements for participation in an optional federal funding program. Congress accordingly has not tread on any power "reserved to the States respectively, or to the people." U.S. Const. Amend. X. The States and their citizens retain their power to "elect to decline a federal

grant." *New York* v. *United States*, 505 U.S. at 168. Nor has Congress impaired the States' power of self-governance under the Guarantee Clause through the provision of monetary incentives for federal participation. U.S. Const. Art. IV, § 4. Congress has "offer[ed] the States a legitimate choice rather than issuing an unavoidable command." *New York* v. *United States*, 505 U.S. at 185.

In sum, the States' constitutional claims in this case are not substantial and therefore do not warrant this Court's extraordinary exercise of its nonexclusive original jurisdiction.

2. The States can readily pursue their claims in alternative fora

Even if the States' claims were more substantial, they would not warrant this Court's exercise of its non-exclusive original jurisdiction, because the States have an adequate alternative forum in which to press their claims. The States, which have not identified their cause of action in this Court, could invoke the jurisdiction of the district courts to pursue judicial relief. See 28 U.S.C. 1331 (granting district courts jurisdiction over civil actions arising under federal law); Administrative Procedure Act, 5 U.S.C. 701 *et seq.* (providing a person suffering legal wrong because of agency action a right to judicial review thereof). The district courts are fully capable of deciding whether the States have stated a claim on which relief can be granted and, if so, whether they are entitled to relief. See, *e.g.*, *Bowen* v. *Massachusetts*, 487 U.S. 879 (1988).

The States acknowledge that they can seek a remedy in federal district court, but they object to that course because, they assert, the issues are ones of "great constitutional magnitude" and "they would face several

years of litigation there and in the court of appeals before the case could be presented to this Court for final resolution by a petition for writ of certiorari." Compl. Mot. 21, 24; see Arizona *et al.*, Amici Br. 18. As explained above, the issues here are not of "great constitutional magnitude," and litigation in the lower courts would most likely confirm that the dispute here is indeed insubstantial and that there is no need for this Court to address the States' claims at all. But even if the States' claims were more substantial, a judicial challenge should begin in the district court, which can make the initial determinations whether a State claim is ripe for judicial examination or warrants preliminary injunctive relief. At bottom, the States' sole objection to the adequacy of the federal district courts rests on the prospect of delay. That objection provides insufficient reason for this Court to act as the tribunal of first and last resort.

First, as noted, the States' constitutional claims appear, at best, highly doubtful. Indeed, it is likely that the States will ultimately realize financial benefits from the MMA's provision of a prescription drug benefit. If particular States have objections as to how Section 1396u-5(c) applies in practice, those States should pursue their specific objections through an appropriate action in district court. This Court should allow the lower courts to perform their normal role of clarifying the points of contention and resolving the disputes, both factual and legal, in the first instance. See, *e.g.*, *McCray* v. *New York*, 461 U.S. 961, 962 (1983) (Stevens, J., opinion respecting denial of petition for a writ of certiorari) ("further consideration of the substantive and procedural ramifications of the problem by other courts will enable us to deal with the issue more wisely at a later date").

Second, it is by no means clear that this Court's exercise of its original jurisdiction would lead to a speedier resolution of the case. This Court's experience in *South Carolina* v. *Regan*, *supra*—the only comparable case in the last quarter century—is instructive. The States filed their motion for leave to file a complaint in 1983, the Court granted leave in 1984, 465 U.S. at 367, and the Court resolved the dispute through entry of a decision in 1988, 485 U.S. 505—a span of five years. That experience is also in line with the time span for a relatively *prompt* resolution of the sort of boundary or water disputes over which this Court has traditionally exercised its original jurisdiction. See, *e.g.*, *Alaska* v. *United States*, 125 S. Ct. 2137 (2005) (more than five-year span from motion for leave to file a complaint to entry of decision); *Virginia* v. *Maryland*, 540 U.S. 56 (2003) (nearly four-year time span from motion for leave to file complaint to entry of decision); *New Jersey* v. *New York*, 523 U.S. 767 (1998) (five-year span between motion for leave to file complaint and entry of decision). Many original actions involving the States have taken far longer. See, *e.g.*, *Arizona* v. *California*, 126 S. Ct. 1543 (2006) (entry of consolidated decree after 53 years of litigation).[10]

Third, it is also instructive that virtually every Supreme Court case that the States rely upon in support of their legal position—including *South Dakota* v. *Dole*, *supra*, *New York* v. *United States*, *supra*, *New*

---

[10] In this case, as in *South Carolina* v. *Regan*, *supra*, the Court presumably would wish to appoint a Special Master to develop the record and determine whether the issues are appropriate for summary judgment. See 465 U.S. at 382. The Special Master would need to examine, for example, whether the issues here are ripe for summary judgment or require further factual development through discovery or trial.

York v. *United States*, 326 U.S. 572 (1946), and *Massachusetts* v. *United States*, 435 U.S. 444 (1978)—reached this Court by way of certiorari or appeal rather than through this Court's exercise of its original jurisdiction. The States have provided no persuasive reason why this case calls for a radically different course. And indeed it does not, because Section 1396u-5(c) is but one example of the countless modifications and adjustments that have occurred in the cooperative federal-state Medicaid program over the years. This Court's original jurisdiction is not the appropriate forum for sorting out and resolving the legal issues that may from time to time arise as that ongoing relationship evolves.

In short, the plaintiff States have provided no compelling reason why this case calls for the Court to take the extraordinary step of extending its original jurisdiction to resolve issues that are within the experience and competence of the federal district courts.

B. The States Cannot Satisfy the Standards for Preliminary Injunctive Relief

Because the States cannot satisfy this Court's standard for obtaining leave to file a bill of complaint, it follows a fortiori that they cannot satisfy the additional requirements for obtaining a preliminary injunction from this Court. To obtain a preliminary injunction, the States must show a likelihood of success on the merits and satisfy the traditional four-factor test for injunctive relief. See *Amoco Prod. Co.* v. *Village of Gambell*, 480 U.S. 531, 546 n.12 (1987); *Weinberger* v. *Romero-Barcelo*, 456 U.S. 305, 312-313 (1982).

For the reasons already given, the States cannot show a likelihood of success on the merits, and the inquiry can end at that threshold. But the States' re-

quest also fails to satisfy the other traditional factors. The States cannot show irreparable injury because the MMA is structured to generate net *savings* for the States and because their failure to comply with Section 1396u-5(c)(1)(B) would simply lead to an offset against the federal government's grant of the future funds for their state Medicaid programs. Moreover, as the attached declaration of an HHS actuary explains, the adjustment itself represents only a small percentage of the overall cost of the States' Medicaid programs. See Decl. of John D. Klemm, App., *infra*, 1a-4a. The reduction for calendar year 2006 is estimated to range from 2.1% to 4.8% of the federal government's contribution to the Medicaid programs of the plaintiff States. See *id.* at 2a-3a. Although the States object to the adjustment, the MMA should provide a larger benefit—in the form of Medicaid program cost savings—in exchange for that reduction, and hence the States are unlikely to suffer any net monetary injury at all. The States claim that Section 1396u-5(c) will lead to state budgetary uncertainty. See Mot. for Prelim. Inj. 5-6. But the amount of the adjustment is based on a statutorily prescribed formula that is based on each State's own per capita expenditures on prescription drugs under Medicaid in the year 2003, and the States in any event always face some uncertainty in projecting their Medicaid costs.

The balance of hardships and the public interest also weigh against the States. Because the MMA is structured to provide the States with Medicaid cost savings that are greater than their payments under Section 1396u-5(c), the States cannot establish that the MMA, on its face, will cause them any financial hardship at all. By contrast, an injunction barring the implementation of Section 1396u-5(c) would deprive the Medicare Part

D program of an important source of the funding necessary to furnish prescription drugs to individuals over 65 or who have disabilities. The injunctive relief that the plaintiff States seek thus would confer on them a windfall of the entire amount of Medicaid cost savings resulting from the federal government's expansion of the Medicare program, with no reduction in federal funding for their Medicaid programs. Finally, the public interest weighs heavily against enjoining carefully considered federal legislation, enacted by representatives of the States, that sets out a fair and sensible mechanism to fund a vital medical benefit for millions of Americans.

An additional equitable consideration strongly reinforces that conclusion. If the States are correct that they did not have to wait for the Secretary's final calculation of the amount of payments and the actual application of the Section 1396u-5(c) adjustment before bringing suit, then the States could have initiated a district court action shortly after the MMA was enacted in 2003. They could then have taken advantage of Congress's postponement of the MMA's effective date, until January 1 of this year, to seek resolution of their claims in the lower courts, without need to invoke this Court's equitable power to provide extraordinary preliminary relief. Because they waited to sue until the Medicare Part D program was already underway, the injunctive relief that they seek would have an immediate disruptive effect on the funding of the agency's program.

In sum, there is no sound basis for this Court, or any court, to grant a preliminary injunction in this case.

CONCLUSION

The motion for leave to file a bill of complaint and the motion for a preliminary injunction should be denied.

Respectfully submitted.

PAUL D. CLEMENT
Solicitor General

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

JEFFREY P. MINEAR
Assistant to the Solicitor General

MARK B. STERN
ALISA B. KLEIN
Attorneys

MAY 2006

In the Supreme Court of the United States

No. 135, Original

STATE OF TEXAS, ET AL., PLAINTIFFS

v.

MICHAEL O. LEAVITT, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON MOTION FOR LEAVE TO FILE BILL OF COMPLAINT AND MOTION FOR A PRELIMINARY INJUNCTION

DECLARATION OF JOHN D. KLEMM

I, John D. Klemm, declare as follows:

1. I am an actuary in the Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS), United States Department of Health and Human Services (HHS). CMS is the federal agency within HHS responsible for administering the Medicare and Medicaid programs. Within OACT, I am an actuary in the Medicare and Medicaid Cost Estimates Group. As leader of the Medicaid team, I have primary responsibility for budget projections and legislative and regulatory cost estimates for the Medicaid program. I am an associate of the Society of Actuaries and a member of the American Academy of Actuaries. The statements made in this declaration are based on my personal knowledge, information contained in agency files,

and information furnished to me in the course of my official duties.

2. I am familiar with the subject matter of the above-captioned lawsuit, which involves the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Pub. L. No. 108-173, 117 Stat. 2066, 42 U.S.C. § 1395w-101 *et seq.* (2003). I understand that the plaintiff States are challenging the validity of 42 U.S.C. § 1396u-5(c), which governs the financing of Medicare prescription drug coverage for individuals who are eligible for Medicaid as well as Medicare ("dual eligibles").

3. I have calculated estimates of the amount of money the federal government will spend on the plaintiff States' Medicaid programs in calendar year ("CY") 2006. I have also calculated estimates of the amount of money the plaintiff States will be responsible for in CY 2006 pursuant to 42 U.S.C. § 1396u-5(c). Those estimates, as well as a percentage comparison, are included in the following table:

State	Estimated CY 2006 State Adjustments (millions of dollars)	Estimated CY 2006 Federal Medicaid Payments to the State (millions of dollars)	State Adjustments as Percentage of Federal Medicaid Payments to the State
Kentucky	72	3,380	2.1%
Maine	39	1,574	2.5%
Missouri	154	4,420	3.5%

New Jersey	238	4,997	4.8%
Texas	261	10,290	2.5%

4. In estimating the amount of money the federal government will spend on the States' Medicaid programs in CY 2006, I relied on certain data that is furnished by the States to CMS. At least once each quarter—November 15, February 15, May 15, and August 15—each State submits to CMS a "Medicaid Program Budget Report" (also known as "CMS-37"). The CMS-37 is a financial report submitted by the States that provides (a) a statement of the State's Medicaid funding requirement for a certified quarter, and (b) estimates and underlying assumptions for the current fiscal year and for the subsequent budgeted fiscal year. This information is supplied by the States to CMS through an electronic system and is then reviewed by CMS. Based on the CMS-37, CMS issues the State a grant award authorizing Federal funding to the State for the certified quarter. The CMS-37 submitted by each State includes estimates regarding total costs of the State's program, the federal share of those costs, and the State share of those costs.

5. The estimates of federal Medicaid payments to the plaintiff States indicated in the table in paragraph 3 are based on information submitted by the States on the form CMS-37 in February 2006.

6. In estimating the amount of money that will be adjusted for each plaintiff State in CY 2006 pursuant to 42 U.S.C. § 1396u-5(c), I used data supplied in notices that have been sent to the States for their January and February 2006 adjustment amounts. On April 13, 2006, CMS sent notices to all States informing them of their adjustment amounts, pursuant to 42 U.S.C. § 1396u-

5(c), for the months of January and February 2006. Using the statutory formula, these adjustment amounts were calculated based on the product of (a) the per-capita amount that each State received in letters from the Secretary of HHS dated February 9, 2006 (attached to States' Motion for Leave to File Bill of Complaint as Exhibits TX 3, KY 2, ME 3, MO 2, NJ 3), and (b) the State's monthly enrollment file submitted to CMS identifying each full-benefit dual eligible individual enrolled in the State for the month. The estimates reflect an assumption that the number of full-benefit dual eligibles in each State will remain relatively constant from month to month. In estimating the CY 2006 adjustments, the amounts for January and February are established as the amounts contained in the notices for those months. The March through December amounts were estimated using the amounts contained in the notice for February 2006, with an adjustment made to reflect any change in a State's Federal Medical Assistance Percentage that will become effective October 1, 2006. 70 Fed. Reg. 71,856-57 (Nov. 30, 2005).

I declare under penalty of perjury that the foregoing is true and correct. Executed this 15th day of May 2006 in Baltimore, Maryland.

/s/ JOHN D. KLEMM
JOHN D. KLEMM, Ph.D., ASA, MAAA