No. 135, Original

In The
Supreme Court of the United States

STATES OF TEXAS, KENTUCKY, MAINE, MISSOURI, AND NEW JERSEY,

Plaintiffs,

v.

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

Defendants.

BRIEF OF PROFESSORS AND PRACTITIONERS OF HEALTH LAW AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS

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INTEREST OF *AMICI CURIAE*[1]

The amici signed below, representing health law and healthcare financing experts, scholars, and practitioners, share the Plaintiff States' objections to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Pub. L. No. 108-173, 117 Stat. 2066, *codified as* 42 U.S.C. § 1395w-101 to -152, as congressional overreaching into areas of traditional state sovereignty.

This brief does not re-argue the constitutional issues described fully in the Plaintiff and amici States' pleadings and briefs. *See* Plaintiff States' Motion for Leave to File Bill of Complaint, Supporting Brief, and Bill of Complaint, at 5-19; Brief of States as Amici Curiae in Support of Plaintiffs, at 3-14. The Health Law amici recognize and adopt those arguments by reference. First, the clawback operates as an unconstitutional tax on States, as States, by mandating that they remit a monthly payment to the federal government to support the new Medicare drug benefit. Second, the clawback impermissibly commandeers state legislative and administrative powers by requiring States to allocate a share of their annual budgets to carry out a federal program. Finally, the clawback violates the constitutional guarantee to a republican form of government by asserting federal control over essential state fiscal decisions and resource allocations.

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[1] Amici hereby certify that the brief is filed with written consent of all parties, which will be lodged with the Court per Supreme Court Rule 37.2(a). Per Rule 37.6, amici also certify that no counsel for either party authored the brief in whole or in part, and that no person or entity, other than amici and their counsel, made any monetary contribution to the preparation or submission of this brief.

The Health Law amici offer their experience and expertise in the detailed operation of the Medicare and Medicaid programs as further insight into the problems likely to result if the Medicaid Part D clawback remains in effect.[2] The immediate and substantial impact of the clawback on States and the nation's health care system warrant the Court's special attention and resolution of this case. Accordingly, the Health Law amici also support and adopt the States' jurisdictional arguments, as described fully in their briefs. *See* Plaintiff States' Brief, at 25-28; Brief of States as Amici Curiae, at 18-20.

SUMMARY OF THE ARGUMENT

Medicare has always been a federally funded program. The mandatory Part D clawback, however, requires States to permanently fund a substantial share of the new federal Medicare prescription drug benefit for "dually-eligible" Medicare-Medicaid beneficiaries, whose drug costs were previously covered by Medicaid. The penalty for States unable or unwilling to pay the Medicare clawback

[2] As the Fourth Circuit, facing a similar issue, declared:

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994).

is automatic loss of Medicaid funds, contrary to the guaranteed entitlement to open-ended federal financial support of health care for individuals that are part of the Medicaid program. The combination of the Part D clawback and Medicaid offset effects fundamental and unprecedented changes in both programs, which together form the nation's health care safety net. In particular, requiring States to fund Medicare Part D as a condition of Medicaid participation may force States to restrict Medicaid eligibility or services. The clawback substantially threatens both programs' effectiveness, if not their very existence.

In addition, the actual operation of the clawback and various aspects of the formula for calculating States' payments intrude on state sovereignty and disrupt essential statutory schemes. The clawback imposes an immediate, substantial burden on States, requiring this Court's timely consideration and resolution. States must pay a substantial share of the new Medicare drug benefit in perpetuity while the federal government retains full authority for calculating the clawback, specifying the manner of payment, notifying States of the amount computed, and collecting payments. The States have no ability to challenge errors, even though the clawback statute and regulations permanently insert inaccuracies into the calculation of the States' payment obligations. Nor can the States respond to their citizens' concerns about state spending or program operation. Speedy consideration of these issues is necessary because state budgets and public benefits programs will be seriously impaired over the several years required to litigate this case through the lower courts in several jurisdictions.

Medicare and Medicaid cover the health care costs of a great number of Americans who would otherwise lack

access to care. More than 45 million Americans are uninsured, according to recent estimates, and the numbers are climbing steadily. Approximately 18 percent of the total U.S. population is uninsured. Almost the same portion, 16 percent, relies on Medicaid and other public insurance coverage. For low income Americans below 100 percent poverty level, 37 percent are uninsured and 42 percent rely on government health insurance.[3] To prevent the expansion of Medicare Part D from exacerbating, rather than remedying, the acute, growing problem of the nation's uninsured, this case requires timely consideration and final resolution.

REASONS FOR GRANTING THE MOTION

I. THIS CASE REQUIRES TIMELY RESOLUTION TO PROTECT THE NATION'S ESSENTIAL HEALTH INSURANCE SAFETY NET.

A. The Part D clawback disrupts the fundamental structure of government health insurance.

Medicare, enacted in 1965, is a federal social insurance program with nationwide, uniform eligibility, coverage, and payment for all beneficiaries. Program eligibility is based on age or disability, rather than financial need. *See* 42 U.S.C. § 426(a), (b). Medicare covers the cost of beneficiaries' hospital services, under Part A, and physician services,

[3] *See* Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *The Uninsured and Their Access to Health Care*, Fact Sheet No. 1420-07, at 1 (Nov. 2005), *available at* http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-Fact-Sheet-6.pdf.

under Part B. Part D adds coverage for outpatient prescription drugs. Medicare traditionally has been funded by mandatory federal payroll taxes, federal general revenue, and beneficiary cost-sharing through premiums and deductibles. *See* 42 U.S.C. §§ 401, 1395e, 1395r-s. States have no fiscal or administrative control over or responsibility for the federal Medicare program.

Prior to the MMA, Medicaid, also enacted in 1965, guaranteed federal subsidies to States willing to establish medical assistance programs for families with limited financial resources and other especially vulnerable individuals. Medicaid is a "cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons." *Bowen v. Massachusetts*, 487 U.S. 879, 883 (1988); *Harris v. McRae*, 448 U.S. 297, 308 (1980). Medicaid is a true "welfare" program in that eligibility is based on income-level below certain poverty standards. Individuals who are both poor, and either disabled or elderly, qualify for both Medicaid and Medicare and thus are termed "dual-eligibles." *See Kozlowski*, 42 F.3d at 1463-64 (Niemeyer, J., concurring in part, dissenting in part) (describing programs). Prescription drug coverage for dually eligible beneficiaries is the issue underlying the Part D clawback.

Medicaid participation is voluntary, but once a state chooses to participate, it must administer its state-specific program consistent with federal requirements. *See* 42 U.S.C § 1396a(b); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 301 (1990); *Harris*, 448 U.S. at 301-02. Participating States must submit plans to federal authorities for approval. State plans must comply with specific statutory requirements, including covering broad categories of

services and beneficiaries. States, in their discretion, may cover additional optional services and beneficiaries. 42 U.S.C. § 1396a(10)(A); *see also* 42 C.F.R. part 440. Prescription drugs are an optional service, 42 U.S.C. § 1396d(a)(12); 42 C.F.R. §§ 440.120(a), 440.225, which all States have opted to include in their Medicaid plans.

Part D changes both Medicare and Medicaid. Dually eligible beneficiaries now will receive prescription drug coverage under Medicare Part D rather than under Medicaid. States will fund the new Medicare benefit via the clawback. Medicaid, traditionally a cooperative endeavor of both the federal and state governments, now could leave States bearing a substantial portion of Medicaid costs without federal support because the penalty for nonpayment of the clawback is loss of Medicaid funding. Under the clawback, States must make monthly deposits into the federal Medicare Prescription Drug Account. *See* 42 U.S.C. § 1396u-5(c)(1)(B); 42 C.F.R. § 423.910(b)(2). If a state fails to make the required payment, the amount owed, plus interest, "shall be automatically offset against amounts otherwise payable to the State" under Medicaid. *See* 42 U.S.C. § 1396u-5(c)(1)(C).

The clawback fundamentally changes Medicare from a fully federal program to a program supported in large part by state dollars but without state fiscal or administrative control. The change not only contravenes the essential nature of Medicare but raises grave constitutional concerns of federal interference with States' appropriations powers and accountability to their citizens. *See* Plaintiff States' Brief, at 13, 17; Brief of States as Amici Curiae, at 8, 13. Equally troubling is the clawback's effect on Medicaid by imposing a significant new requirement on States' participation. States may lose essential Medicaid funding,

to which they are entitled as program participants, for failing to comply with a separate, unconditional demand under the Medicare statute. Those unprecedented changes to both programs cannot stand and should be timely resolved by the Court's granting the Plaintiff's Motion.

B. Depriving States of federal financial support contravenes Medicaid's three entitlements.

Medicaid creates three distinct entitlements to payment for program participants:[4] First, participating States are entitled to federal funding. *See* 42 U.S.C. § 1396b(a), (d). Second, Medicaid enrollees are entitled to medical care. *See Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006); *Doe v. Chiles*, 136 F.3d 709, 719 (11th Cir. 1998). Finally, health care providers are entitled to payment for the cost of treating Medicaid enrollees. *See Wilder*, 496 U.S. at 512; *Pediatric Specialty Care*, 443 F.3d at 1015-16. The clawback endangers all three entitlements.

First, the clawback and Medicaid offset deny States' entitlement to federal funding. The Medicaid statute requires States to pay for all covered services for eligible enrollees, regardless of the level or cost of services. *See* 42

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[4] *See generally* Timothy S. Jost, *The Tenuous Nature of the Medicaid Entitlement*, HEALTH AFFAIRS, Jan.-Feb. 2003, at 145, 147-48; Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMEDICAL L. 1, 7 (2004); Victoria Wachino et al., *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*, Kaiser Commission on Medicaid and the Uninsured, Policy Brief No. 7000, at 3-6 (Jan. 2004).

U.S.C. § 1396a. Likewise, the federal government agrees to match state spending for both required and optional Medicaid services. *See* 42 U.S.C. § 1396b. The federal matching percentage, which ranges from 50-83%, is based on States' relative wealth, with the poorest States receiving the highest matching percentages. *See* 42 U.S.C. §§ 1396b, 1396d(b); 42 C.F.R. §§ 433.10, 434.70. As long as costs are Medicaid-related, States are "entitled" to their federal matching share without caps. This "cooperative federalism" funding arrangement is the "cornerstone of Medicaid," *Harris*, 448 U.S. at 308, and was intended as an incentive for States to expand their Medicaid programs and provide generous health insurance for especially needy individuals.[5] The more generously a state spends out of its own budget on Medicaid, the more the state receives in corresponding federal dollars. On the other hand, a state that reduces Medicaid spending by cutting services or restricting eligibility, faces a corresponding reduction in federal financial support.[6]

The clawback violates States' entitlement to open-ended, dollar-for-dollar, Medicaid matching funds by tying those dollars to States' unconditional obligation to pay for the new Medicare prescription drug benefit. The loss of

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[5] *See* Social Security Amendments of 1965, S. REP. NO. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1934, 1951 (explaining federal matching share as "uniform formula with no maximum on the amount of expenditures which would be subject to participation"); Wachino et al., *supra* note 3, at 3 (noting that federal payments are not subject to predetermined limits).

[6] Wachino et al., *supra* note 3, at 7 ("Medicaid's financing structure, under which federal payments can increase when need for the program expands and decrease when need for the program falls, is fundamental to the individual entitlement that the program provides.").

federal Medicaid dollars has the effect of "drop[ping] the total cost of providing the service on States, [which] runs directly counter to the basic structure of the program and could severely cripple a state's attempts to provide other necessary medical services embraced by its plan." *Harris*, 448 U.S. at 309, n.12 (citing *Preterm, Inc. v. Dukakis*, 591 F.2d 121 (1st Cir. 1979)). Up to the amount of the Part D clawback offset, States' Medicaid spending will be unmatched by federal support, upsetting the fundamental cooperative approach. States that continue to spend generously on their Medicaid programs now stand to lose federal support due to an entirely separate mandate. The loss of entitlement results not from failing to comply with any Medicaid conditional requirements of Medicaid participation, but from failing to comply with a mandatory requirement to fund the federal Medicare program. States that operate fully compliant Medicaid programs nevertheless may lose federal matching dollars if they are unable or unwilling to comply with the clawback. That penalty violates States' fundamental Medicaid entitlement.

The clawback also threatens Medicaid's other two entitlements to Medicaid enrollees and participating health care providers. States losing federal funding for Medicaid under the clawback have two options: First, they can reduce state program budgets by restricting eligibility, limiting services, or reducing costs. Alternatively, they can allocate additional state funds to make up the funding shortfall and maintain their existing programs. Financially strapped States may be unable to do the latter, but if they opt for the former, they could face liability from both Medicaid enrollees, for denying entitlement to medical care, and providers, for denying entitlement to payment.

Beyond the potential entitlement claims, States that attempt to reduce spending by limiting existing Medicaid enrollment and provider payment exacerbate the nation's health care crisis. Since its enactment, Medicaid has made great strides in improving healthcare access for low-income and medically vulnerable individuals.[7] But under the clawback, States may be unable to maintain their Medicaid programs. Reducing eligibility pushes needy individuals off of government insurance rolls into the ever-increasing uninsured population. Reducing payment causes providers to opt out of program participation and decline to treat Medicaid enrollees. Perversely, the poorest States, which may be least able to comply with the claw-back and receive the highest percentage Medicaid matching dollars, take the hardest hit under the Part D automatic penalty. The combined effect endangers the overall level of health in the population and increases States' welfare and fiscal challenges.[8]

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[7] *See* Mark L. Berk & Claudia L. Shur, *Access to Care: How Much Difference Does Medicaid Make?*, HEALTH AFFAIRS, May-June 1998, at 169-80.

[8] As one court eloquently noted, considering beneficiaries' 42 U.S.C. § 1983 challenge, underlying the

> statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official government reports, periodicity tables, etc. . . . [L]et there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications . . . for their children, AIDs patients unable to get treatment, elderly persons suffering from chronic conditions like diabetes and heart disease. . . .

Salazar v. District of Columbia, 954 F. Supp. 278, 281 (D.D.C. 1996).

II. FLAWS IN THE CLAWBACK FORMULA IMMEDIATELY AND SUBSTANTIALLY BURDEN STATE BUDGETARY PROCESSES AND REQUIRE SPEEDY RESOLUTION.

The formula for calculating States' clawback payments permanently affixes federal control over and payment inaccuracies into states' budgetary processes. Already, the States collectively expect to pay billions of dollars in just the first two years of MMA operation. *See* Plaintiff States' Brief, at 23; Brief of States as Amici Curiae, at 17. The "phased-down state contribution," or clawback, formula is expressly stated in the MMA and implementing regulations. *See* 42 U.S.C. § 1396u-5(c)(1)(A); 42 C.F.R. §§ 423.908, 423.910. The formula is intended to approximate the amount that States would have spent on prescription drug benefits for dually eligible beneficiaries before MMA took over the benefit.[9] Both the clawback and the requirement that dually eligible beneficiaries enroll in Part D, rather than Medicaid, prescription drug coverage were eleventh-hour amendments to the MMA intended to address budget overruns. In the finally enacted version, federal authorities retain full authority for administering the clawback. *See* 42 U.S.C. § 1396u-5(c)(1)-(4); 42 C.F.R. §§ 423.902, 423.908, 423.910. The clawback formula consists of three components: (1) state per capita expenditures for dual-eligibles' prescription drug coverage; (2) number of enrolled dual-eligibles; and (3) phased-down percentage. *See* 42 U.S.C. § 1396u-5(c)(1)(A).

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[9] *See Testimony of Mark B. McClellan, CMS Administrator, Before the Senate Finance Committee Hearing on Implementation of the New Medicare Prescription Drug Benefit*, at 34 (Feb. 8, 2006) (explaining that clawback was intended "to account for a portion of the costs that states had previously paid for Medicare beneficiaries who are also in Medicaid").

Although referred to in the statute and regulations as a "phased-down" contribution, state's Part D funding obligation never phases out entirely. The Secretary retains broad discretion in adjusting, computing, and re-calculating States' required payments. Therefore, a substantial portion of States' annual budgets are perpetually under federal control, violating the inter-governmental tax immunity and anti-commandeering doctrines. *See* Plaintiff States' Brief, at 13-14; Brief of States as Amici Curiae, at 4. Moreover, several elements of the formula perpetuate the unconstitutional and uncontrollable fiscal impact on States. Those flaws are already having a substantial impact on States, warranting the Court's intervention.

A. The calculation of per capita expenditures inaccurately estimates States' drug costs for dually eligible beneficiaries.

The first component of the clawback formula is intended to estimate States' per capita spending on dually eligible beneficiaries' prescription drug costs. But the estimate is grossly inaccurate because of various flaws in the formula. The per capita estimate is calculated on a monthly basis and derives from the States' 2003 spending for dual-eligibles' drug costs, trended forward. *See* 42 U.S.C. § 1396u-5(c)(2)(A)(i); 42 C.F.R. §§ 423.902, 423.910(b). The 2003 base year is problematic because it perpetually and arbitrarily holds States to their 2003 Medicaid spending levels, with no room for adjustment or correction, even if States' Medicaid drug spending in 2003 bears no relation to spending in 2006 and beyond. In addition, the formula fails to account for any interim cost-saving measures that

States may have implemented between 2003 and 2006,[10] inflating States' estimated spending in the years leading up to Part D implementation, denying them the fiscal benefit of increased efficiency or cost reductions, and granting the federal government a windfall.

The 2003 base year also penalizes States that historically offered especially generous prescription drug benefits. States have had full discretion over the scope of Medicaid prescription drug coverage. Therefore, States that offered broader coverage than others will perpetually pick up a larger share of the federal tab for Medicare Part D, without regard to those States' relative wealth or currently available resources. In effect, the clawback permanently penalizes States for past generosity and expanded public benefits programs.

Further flaws in the first component of the clawback formula derive from the inflation adjustment factor. Starting from 2003 base-year spending, the amount is trended forward, theoretically to reflect rising prescription drug costs over time. *See* 42 U.S.C. § 1396u-5(C)(2)(A)(ii); 42 C.F.R. § 423.902. The growth factor used is the average annual percent increase in per capita drug spending nationally, for all populations, since 2003. That figure inaccurately relies on a nationwide inflation factor,[11]

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[10] Forty-six out of 50 States implemented some type of Medicaid pharmacy cost-savings reforms during state fiscal year ("SFY") 2003; 44 took action in 2004, which efforts will not be reflected in the amount States required to pay to the federal government. *See* CONGRESSIONAL RESEARCH SERVICE ("CRS") REPORT FOR CONGRESS, IMPLICATIONS OF THE MEDICARE PRESCRIPTION DRUG BENEFIT FOR STATE BUDGETS, at 3 (June 23, 2004).

[11] Current nationwide inflation projections are approximately 11%. *See* Stephen Heffler, et al., *Health Spending Projections through 2013*,

(Continued on following page)

rather than state-specific or region-specific factors. Variations such as regional practice preferences, marketing, and drug plan formularies could cause differing rates of increase in prescription drug costs across States and regions.[12]

A second problem with the inflation adjustment is that it is based on all prescription drug spending for all populations, not just Medicare Part D covered drugs, at least for the first three years of the program. *See* 42 C.F.R. § 423.902. Medicare-covered prescription drug costs and patient utilization could be much lower than nationwide drug spending and utilization levels. But States' clawback payments will not reflect that discrepancy, at least initially.

B. The number of dually eligible beneficiaries may increase dramatically under Part D, exceeding historical costs.

The second component of the formula, the number of dually eligible Medicare Part D enrollees places States' budgets at the mercy of federal authorities, who have full control and discretion over Medicare. *See* 42 U.S.C. § 1396u-5(c)(2)(A)(ii). Unlike Medicaid, over which States exercise broad discretion with respect to enrollment,

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HEALTH AFFAIRS, Web Exclusive, Feb. 11, 2004, *available at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.79v1/DC1.

[12] *See* CRS Report, *supra* note 9, at 3 (describing state and regional variations). *But see* Centers for Medicare & Medicaid Services, Medicare Program; Medicare Prescription Drug Benefit, Final Rule, 70 Fed. Reg. 4194, 4422 (Jan. 28, 2005) (declining to adopt state-specific inflation factors because that approach would be "imprecise and would introduce new reporting requirements").

eligibility, and coverage, States have no authority or control over Medicare operations. If Congress statutorily expands Medicare eligibility or federal authorities ease enrollment processes, States face corresponding increases in dually eligible Medicaid enrollment and, accordingly, clawback liability. Moreover, the new Part D benefit could have a "woodwork" effect of encouraging previously unenrolled individuals to sign up for government health insurance. Much of States' anticipated savings from the federal government's assuming responsibility for dually eligible prescription drug benefit could be largely lost in increased state Medicaid enrollment.[13]

Congress and the courts have previously recognized that changing Medicare eligibility may have detrimental fiscal impact on States. In the past, Congress gave States alternatives to ease the financial pressure and prevent an exodus of Medicaid participation. For example, when Congress added the federal Supplemental Security Income for the Aged, Blind, and Disabled ("SSI") program, it also declared that all SSI recipients were automatically entitled to Medicaid. Accordingly, the SSI amendment "threatened to swell the Medicaid rolls and place a large and immediate fiscal burden on participating states." *Winter v. Miller*, 676 F.2d 276, 278 (7th Cir. 1982). "Congress feared that these states would withdraw from the cooperative Medicaid program rather than expand their Medicaid

[13] *See* Congressional Budget Office ("CBO") Cost Estimate, H.R. 4954, Medicare Modernization and Prescription Drug Act of 2002, As ordered reported by the House Committee on Ways and Means, at 13 (June 19, 2002) (reducing CBO's initial $58 billion estimate of savings to States, over 2003-2012, to approximately $12 billion, after offsets for increased spending on new dual-eligible enrollees and other factors); CRS Report, *supra* note 9, at 5-6 (noting potential increase in total state Medicaid expenditures from Part D screening process).

coverage," which would undermine the legislative purpose behind both Medicaid and SSI. *Schweiker v. Gray Panthers*, 453 U.S. 34, 38 (1981). Therefore, Congress gave states an alternative – the so-called "section-209(b) option" – to automatically enrolling new SSI recipients. Fifteen States opted to be section-209(b) States. *Schweiker*, 453 U.S. at 39 & n.6; *Miller*, 676 F.2d at 278. No comparable safety-valve or alternative exists under Part D to assist States in absorbing the "woodwork" effect and increased enrollment resulting from Medicare Part D expansion. Part D pressures carry the very real possibility of States being forced to withdraw from Medicaid participation or severely limit state plans.

C. The clawback requires States perpetually to fund the Part D benefit, with no phase-out.

States are perpetually required to fund a substantial portion, never less than 75%, of the federal Medicare prescription drug benefit. The third component of the clawback formula is a statutory schedule of States' required phase-down contribution. For 2006, the first year of Part D implementation, the States clawback obligation is 90 percent of dually eligible drug costs. 42 U.S.C. § 1396u-5(c)(5)(A). That staggering fiscal demand decreases gradually over several years but remains permanently fixed at 75 percent, for 2015 and thereafter. 42 U.S.C. § 1396u-5(c)(5)(J). Like the clawback itself, this phase-down was a last-minute congressional compromise designed to address the MMA budget overrun.

The clawback did not appear in the MMA until almost the final version. Neither the House nor Senate Bill contained a clawback provision, much less required dually eligible beneficiaries to enroll in Medicare prescription drug coverage. The Senate Bill, in fact, required dually

eligible beneficiaries to continue receiving drug coverage under Medicaid. The House Bill allowed dually eligible beneficiaries optional enrollment in Part D while retaining "wrap-around" Medicaid drug coverage. Under the House version, States would contribute to the federal benefit for Part D optional enrollees, but the payment obligation would phase out completely over time.[14]

The clawback emerged from a House-Senate Conference Agreement in November 2003. To keep the new law within the Administration's $400 billion budget, conferees added three offsets: (1) monthly premium payments for Part D enrollees; (2) federal savings in the amount of Medicaid matching funds no longer required for dually eligible drug costs; and (3) the clawback. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. 1, H.R. CONF. REP. No. 108-391, 108th Cong., 1st Sess., 91, 506 (Nov. 21, 2003). The state clawback represents the largest offset, fixed as a permanent, primary funding source for the new Part D benefit, along with federal tax revenue and enrollee contributions.

The legislative history behind the clawback reveals the reality of the funding arrangement. The House proposal cast the clawback not as federal assumption of the overall cost of dual-eligibles' drug benefits, with "phased-down" state contribution but as "phased-in" federal assumption of the "administrative costs" of the benefit.[15] Reference to "administrative"

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[14] *See* Health Policy Alternatives, Inc., *Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of S. 1 and H.R. 1 and the Conference Agreement (H.R. 1)*, at 4-5 (Nov. 26, 2003), *available at* www.kff.org/medicare/6111.cfm.

[15] The initial conference report proposal would have phased-out state contribution (or "phased-in" 100 percent federal assumption of costs) by 2019. *See* H.R. CONF. REP. No. 108-391, at 506.

costs and federal "phase-in" imply that States retain primary fiscal and administrative responsibility for the drug benefit, with limited federal support for "administrative," not actual, drug costs. In reality, the federal government claims full credit for expanding Medicare, while bearing only a portion of the costs. States receive no credit for funding the new program. Nor do they retain any ability to control or respond to constituents' concerns about the program, undermining States' accountability and guaranteed right to a republican form of government. *See* Plaintiff States' Brief, at 18-20; Brief of States as Amici Curiae, at 10-14. Along with full control over Part D, the federal government retains the authority, in the future, to increase States clawback payments or demand additional state contributions if Medicare Part D expenditures continue to overrun expectations.

The clawback scheme disrupts and endangers the nation's health insurance safety net, which provides coverage for close to one-fifth of the nation's population. Although touted as a generous and unprecedented expansion of traditional Medicare,[16] the new drug benefit threatens to unravel both Medicare and Medicaid. The potentially serious impact on States' essential budgetary functions and public benefits programs warrants this Court's timely consideration of the issues raised in the Complaint. During

[16] White House Office of the Press Secretary, Fact Sheet: Medicare Prescription Drug, Improvement, Modernization Act of 2003 (Dec. 8, 2003) (suggesting that MMA will "help to create a modern Medicare system, allow for the biggest improvements in senior health care in nearly 40 years, and provide seniors with prescription drug benefits and more choices in health care" and "[f]or the first time in Medicare's history, a prescription drug benefit will be offered to all 40 million seniors and disabled Americans") *available at* http://www.whitehouse.gov/news/releases/2003/12/20031208-3.html.

the several years that would pass if the Plaintiffs are required to litigate their claims through various jurisdictions and lower courts, States fiscal operations and Medicaid enrollees' health care could be severely and detrimentally impacted. This Case's serious implications for the nation's health care system warrant special consideration, and no adequate alternative forum exists to address those concerns. *See* Plaintiff States' Brief, at 23-24; Brief of States as Amici Curiae, at 17-18. Therefore, this Court should exercise its original jurisdiction to consider the important issues raised and strike down the Part D clawback.

CONCLUSION

The Court should grant the motion for leave to file the complaint.

Respectfully submitted,

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