Case No. 14-1300

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

MARY C. MAYHEW, in her capacity as Commissioner of the Maine Department of Health and Human Services,

Petitioner,

v.

SYLVIA M. BURWELL, in her capacity as Secretary of Health and Human Services,

Respondent,

and

JANET T. MILLS, in her capacity as Attorney General of Maine,

Interested Party-Intervenor.

ON PETITION FOR REVIEW FROM A DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

AMICI BRIEF OF THE NATIONAL HEALTH LAW PROGRAM, MAINE EQUAL JUSTICE PARTNERS, MAINE PSYCHOLOGICAL ASSOCIATON, MAINE CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, MAINE MEDICAL ASSOCIATION, PREBLE STREET, MAINE CHILDREN'S ALLIANCE, AND YOUNG INVINCIBLES AS AMICI CURIAE IN SUPPORT OF RESPONDENT AND URGING AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *amici curiae* the National Health Law Program, Maine Equal Justice Partners, Maine Psychological Association, Maine Chapter of the American Academy of Pediatrics, Maine Medical Association, Preble Street, Maine Children's Alliance, and Young Invincibles disclose that they have no parent corporations and are nonprofit entities that issue no stock. Accordingly, no publicly held corporation owns 10 percent or more of their stock.

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INTEREST OF AMICI

The *amici* file this brief pursuant to Fed. R. App. P. 29. All parties have consented to its filing. Founded in 1969, the National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals. It is the oldest non-profit of its kind. NHeLP advocates, educates, and litigates at the federal and state levels to further its mission of improving access to quality health care for low-income individuals, particularly young people. Given this mission, NHeLP has a strong interest in the outcome of this case.

Maine Equal Justice Partners, Inc. is a state-wide non-profit civil legal aid advocacy organization whose mission is to find solutions to poverty and improve the lives of people with low income in Maine. One of our major areas of focus is access to quality, affordable health care for Maine's low-income population. Our predecessor organization advocated for Maine to cover 19 and 20 year-olds when Maine adopted this coverage, and we have since opposed efforts to reduce this coverage. We believe that continued access to medically necessary care is crucial if these children are to successfully transition to lives of higher education and employment.

The purpose of the Maine Psychological Association is to advance psychology as a science, as a profession, and as a means of promoting health and human welfare. Behavioral care is an important component of health care for

everyone, including young people. Adolescence to early adulthood can be a critical time for the progression of mental health problems. According to the National Institute of Mental Health, about 75 percent of mental illnesses begin by the age of 24. Access to treatment during this period can play an important role in preventing crises later in life, as well as improving overall psychological and mental health as people age.

The Maine Chapter of the American Academy of Pediatrics (Maine AAP) is a non-profit organization representing the approximately 220 pediatricians who practice in Maine. Our mission is to "improve the lives of children and adolescents in Maine." Maintaining access to health care for low-income 19 and 20 year-olds directly furthers that mission. Decades of research demonstrates the strong correlation between insurance coverage and improved health and well-being for young people.

The mission of the Maine Medical Association (MMA) is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens. Founded in 1853, the MMA is a non-profit professional membership organization of more than 4200 physicians, residents, and medical students in Maine and is a component society of the federation of the American Medical Association. The MMA believes strongly that we cannot resolve the problems in the American health care system without ensuring adequate health

insurance coverage for all residents and, therefore, the organization has a great interest in protecting Medicaid coverage and access to care for 6500 low-income 19 and 20 year-olds.

Preble Street has provided accessible barrier-free services for people experiencing problems with homelessness, housing, hunger, and poverty and advocated for solutions to those problems since 1975, developing and operating innovative, collaborative services for Maine's most disadvantaged and underserved citizens. Among the greatest unmet needs is access to affordable health care for teens and adults. Preble Street Teen Services through its Teen Center, Joe Kreisler Teen Shelter, First Place transitional living program, and Anti-Trafficking Coalition works with more than 400 homeless youth each year. Many of these 19 and 20 year-olds rely on Medicaid for their comprehensive medical needs, including physical health, mental health, addiction and case management services provided by our Teen Center collaborative partners or us.

Founded in 1994, the mission of the Maine Children's Alliance (MCA) is to advocate for sound public policies that improve the lives of children, youth, and families in Maine. By collecting and analyzing data on children and their health, economic and educational status, MCA seeks to link research to practice and public policy. Children and youth who have health insurance are more likely to have a stable source of preventive health care. As research shows, uninsured

children are more likely to go without needed health care, lack access to prescription medicines, and experience worse health outcomes than those with coverage. MCA strongly believes that Medicaid coverage and access to health care for low-income 19 and 20 year-olds is crucial to their successful transition to adulthood.

Young Invincibles (YI) is a national, non-profit organization committed to promoting economic opportunity for young people ages 18 to 34. YI was founded in 2009 to raise the voices of young people in the debate over health care reform, and ensuring all young people have access to health care continues to be central to our mission. About one quarter of Mainers ages 19 and 20 have incomes below the federal poverty level. If approved, Maine's proposal to eliminate coverage for 19 and 20 year-olds would adversely affect the health, well-being, and economic opportunities of low-income young people in Maine. [1]

SUMMARY OF THE ARGUMENT

Maine has provided Medicaid coverage to children ages 19 and 20 since 1991.[2] In 2012, Maine submitted a state plan amendment (SPA) that proposed to

[1] No party's counsel authored this brief in whole or in part, and no party or party's counsel contributed money intended to fund preparing or submitting this brief. No person, other than *amici*, *amici*'s members, and *amici*'s counsel, contributed money intended to fund preparing or submitting the brief.

[2] In her brief, the Commissioner refers to individuals ages 19 and 20 as adults, even though she has recognized that federal law gave Maine the option to provide them with Medicaid coverage because of their status as children. *See* App. 8.

eliminate Medicaid coverage for these children.[3] At issue in this case is the United States Department of Health and Human Services' denial of the SPA on the grounds that it violates the maintenance of effort provision in the Patient Protection and Affordable Care Act (ACA).

If approved, the SPA will have serious consequences for the health of low-income children ages 19 and 20 in Maine. These children, who depend on Medicaid for their health care, have significant health needs. Congress has recognized the importance of access to affordable health care for children since the Medicaid program began in 1965. Congress designed Medicaid to cover vulnerable low-income populations, including children under age 21, and soon thereafter amended the law to mandate that states cover a comprehensive set of preventive and treatment services for Medicaid enrollees under age 21. Moreover, since 1965, Congress has used maintenance of effort provisions that have preserved children's access to Medicaid and related public benefits.

Given that individuals ages 19 and 20 are children for Medicaid purposes, this brief refers to them as such.

[3] The SPA would not eliminate Medicaid coverage for independent foster children and state adoption children. App. 8.

ARGUMENT

I. If Approved, the SPA Will Have Serious Consequences for the Health of Low-Income Children Ages 19 and 20 in Maine

As of March 1, 2014, 6484 Maine residents ages 19 and 20 were enrolled in Medicaid through the eligibility category that the state hopes to eliminate. Me. Dept. of Health and Hum. Servs., *MaineCare Case Load DSS Data as of March 2014* (2014). These children depend on Medicaid to meet their health needs, which are often substantial.

A. Children Ages 19 and 20 Have Serious Health Needs

Children ages 19 and 20 have significant health concerns. This population suffers from high rates of mental illness, substance use and abuse, and sexually transmitted infections.[4] In general, these health conditions are preventable and treatable. *See* Elizabeth M. Ozer et al., *Young Adult Preventive Health Care Guidelines: There But Can't Be Found*, 166 Archives of Pediatric and Adolescent Med. 240, 240 (2012). The American Academy of Pediatrics recommends that primary care providers screen children ages 19 and 20 for each of these health conditions. *See* Am. Acad. of Pediatrics, *Recommendations for Preventive Pediatric Health Care* (2014), *available at* http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.

[4] Individuals in this age range also experience other significant health concerns, such as injury and obesity. *See* Tina Paul Mulye et al., *Trends in Adolescent and Young Adult Health in the United States*, 45 J. Adolescent Health 8 (2009).

Mental illness: Alarming numbers of children ages 19 and 20 suffer from mental illness. Approximately 19 percent of children ages 19 and 20 have had a diagnosable mental illness other than a substance use disorder in the past year.[5] Substance Abuse and Mental Health Servs. Admin. (SAMHSA), Results From the 2012 National Survey on Drug Use and Health: Mental Health Detailed Tables, Adult Mental Health Tables, Table 1.1B, http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsLOTSect1pe2012.htm#TopOfPage (last visited Aug. 7, 2014). Moreover, certain mental health conditions are most prevalent among individuals in this age range. Individuals ages 18 to 25 have a higher rate of co-occurring substance use disorder and mental illness than individuals ages 26 to 49 and age 50 and older. Likewise, individuals ages 18 to 25 have serious thoughts of suicide, make plans to commit suicide, or attempt suicide at a higher rate than older individuals. *Id*. at Table 1.4B, 1.49B. Across all of these age groups, the rate of mental illness increases as income decreases. Mental illness is most prevalent among individuals with incomes below the federal poverty level. *Id*. at Table 1.3B. Taken together, these statistics suggest that children ages 19 and 20 who receive Medicaid coverage have a disproportionate need for mental health treatment services due to their age and income status.

[5] SAMHSA does not use consistent age groups to report data. This brief uses the most age-specific data available for each measure.

The importance of receiving treatment for mental illness at this age cannot be overstated. Treatment "can minimize impairments associated with mental health problems while supporting the transition to independence and adulthood." SAMHSA, *The CBHSQ Report: Serious Mental Health Challenges Among Older Adolescents and Young Adults* (May 6, 2014), http://www.samhsa.gov/data/2K14/CBHSQ173/sr173-mh-challenges-young-adults-2014.htm. As a result, the federal government has noted that meeting the behavioral health needs of this population has long-term consequences and should be prioritized. *Id*. Cost, however, remains a major barrier to treatment, with almost half of all individuals age 18 and older who have an unmet need for mental health treatment citing cost as a reason for not receiving the treatment. SAMHSA, Results From the 2012 National Survey on Drug Use and Health: Mental Health Detailed Tables, Adult Mental Health Tables, Table 1.43B, http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsLOTSect1pe2012.htm#TopOfPage (last visited Aug. 7. 2014).

Substance use and abuse: Staggering numbers of children in this age range use tobacco products, drink alcohol in excess, or use illicit drugs. Approximately 35 percent of children ages 18 to 20 have used tobacco products in the past month, and approximately 47 percent have used them in the past year. SAMHSA, Results From the 2012 National Survey on Drug Use and Health: Detailed Tables, Tobacco

Product and Alcohol Use Tables, Table 2.5B, http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsLOTSect2pe2012.htm (last visited Aug. 7, 2014). Approximately 31 percent of children ages 18 to 20 report binge drinking alcohol in the past month, with binge drinking defined as consuming five or more drinks on the same occasion. A third of those children report consuming five or more drinks on the same occasion at least five times in the past month. *Id*. Approximately 24 percent of children ages 18 to 20 have used illicit drugs in the past month, and approximately 40 percent have used them in the past year. SAMHSA, Results From the 2012 National Survey on Drug Use and Health: Detailed Tables, Illicit Drug Use Tables, Table 1.5B, http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsLOTSect1pe2012.htm#TopOfPage (last visited Aug. 7, 2014).

Given these statistics on substance use, it is not surprising that substantial numbers of children ages 19 and 20 have a diagnosable substance use disorder. Among individuals age 19, approximately 12 percent have demonstrated alcohol abuse or dependence in the past year, and approximately 9 percent have demonstrated illicit drug abuse or dependence in the past year. The statistics are similar for individuals age 20. SAMHSA, Results from the 2012 National Survey on Drug Use and Health: Detailed Tables, Dependence, Abuse, and Treatment

Tables, Table 5.3B, http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsLOTSect5pe2012.htm (last visited Aug. 7, 2014).

Given these figures, prevention of and treatment for substance use and abuse is critical for individuals ages 19 and 20. The long-term health effects of tobacco use have been well-documented. *See, e.g.*, Ctrs. for Disease Control and Prevention, Nat'l Ctr. For Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, *The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General* (2014), *available at* http://www.surgeongeneral.gov/library/reports/50-years-of-progress/. In fact, tobacco use is the leading actual cause of death in the United States. Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 JAMA 1238, 1239-40 (2004). Alcohol and illicit drug use and abuse can cause acute health crises and long-term health problems, ranging from unintentional injury to organ damage and death. *See* Ctrs. for Disease Control and Prevention, *Fact Sheets – Alcohol Use and Health*, http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm (last updated Mar. 14, 2014); Nat'l Inst. on Drug Abuse, *Medical Consequences of Drug Abuse*, http://www.drugabuse.gov/related-topics/medical-consequences-drug-abuse (last updated Dec. 2012). But, cost often prevents individuals with a substance use disorder from receiving treatment. Almost 40 percent of people age

12 and older who both need treatment for illicit drug or alcohol abuse and recognize their need for treatment cite not having insurance or not being able to afford the treatment despite having insurance as a reason for not receiving the treatment. SAMHSA, Results from the 2012 National Survey on Drug Use and Health: Detailed Tables, Dependence, Abuse, and Treatment Tables, Table 5.56B, http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsLOTSect5pe2012.htm#TopOfPage (last visited Aug. 7, 2014).

Sexually transmitted infections (STIs): According to the Centers for Disease Control and Prevention (CDC), individuals ages 15 to 24 face the highest risk of acquiring STIs "for a combination of behavioral, biological, and cultural reasons." Ctrs. for Disease Control and Prevention, Div. of STD Prevention, *Sexually Transmitted Disease Surveillance 2012* 59 (2014), *available at* http://www.cdc.gov/sTD/stats12/Surv2012.pdf.[6] CDC data show that individuals ages 15 to 24 account for 25 percent of the sexually experienced population, but 50 percent of new STIs. Ctrs. for Disease Control and Prevention, *Fact Sheet: Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States* (2013), *available at* http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf. In particular, chlamydia and gonorrhea are most prevalent among

[6] With some exceptions, this CDC report presents data on the prevalence of STIs according to age groups (15-19, 20-24, 25-29, etc.) This brief uses the most age-specific data available for each measure.

women age 19, and syphilis is most prevalent among men ages 20 to 24. *See* Ctrs. for Disease Control and Prevention, Div. of STD Prevention, *supra*, at 11, 21, 35, 92, 104. In addition, the rate of HIV diagnosis is highest among individuals ages 20 to 24. Ctrs. for Disease Control and Prevention, *HIV Among Youth* (2014), *available at* http://www.cdc.gov/hiv/pdf/risk_youth_fact_sheet_final.pdf.

If left untreated, STIs can cause long-term health problems. In women, chlamydia and gonorrhea can cause pelvic inflammatory disease, which is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Ctrs for Disease Control and Prevention, Div. of STD Prevention, *Sexually Transmitted Disease Surveillance 2012* 5, 14 (2014), *available at* http://www.cdc.gov/sTD/stats12/Surv2012.pdf. When a pregnant woman has syphilis, the infection can pass to the fetus, and in some cases, cause perinatal death. *Id*. at 28. In addition, evidence suggests that chlamydia, gonorrhea, and syphilis facilitate transmission of HIV. *Id*. at 5, 14, 28. Individuals who do not receive treatment for HIV will develop AIDS, which is fatal if left untreated. Ctrs for Disease Control and Prevention, *About HIV/AIDS, What Are the Stages of HIV*, http://www.cdc.gov/hiv/basics/whatishiv.html (last updated Feb. 2, 2014). Even for individuals who have insurance, treating STIs, particularly HIV, can be unaffordable due to cost-sharing requirements. *See, e.g.*, Fair Pricing Coalition, *Health Insurance Marketplace Plans and People Living with HIV and/or Viral*

Hepatitis: The Affordable Care Act Requires Fair Drug Pricing and Access (2014), *available at* http://fairpricingcoalition.org/wp-content/uploads/2014/02/FPC-QHP-Policy-Guide-Feb-2014-1.pdf.

II. Children Under Age 21 Have Been a Focus of the Medicaid Program For Almost Five Decades

A. Congress Designed Medicaid to Cover Vulnerable Children Under Age 21

In 1965, Congress enacted Medicaid to offer states the option to participate in a federal-state cooperative partnership intended to improve access to health care and the health status of poor Americans. Congress envisioned that Medicaid would cover the most vulnerable populations – people with disabilities, the blind, seniors, and families with dependent children. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2605-2606 (2012). States that chose to participate in the program were required to make medical assistance available to low-income residents who were receiving public benefits through one of five existing federal-state cooperative programs, including Aid to Families with Dependent Children (AFDC). Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(10), 79 Stat. 286, 345. At that time, the AFDC program provided cash assistance to certain families with children under age 18 or with children ages 18 to 20 who met specific educational requirements. 42 U.S.C. § 606(a) (1964) (defining "dependent child" for purposes of AFDC).

Congress did not want to import this disparate treatment of children based on age into the Medicaid program. Consequently, in addition to requiring that states provide medical assistance to children who were receiving cash assistance through AFDC, Congress required that states cover low-income children under age 21 who were not receiving cash assistance, but would have qualified for AFDC but-for their age.[7] Social Security Act Amendments of 1965 §§ 1902(a)(10), 1902(b)(2), 1905(a). The report of the Senate Finance Committee explains Congress' thinking: "Thus, States will include within the scope of their plan all children under the age of 21 – whether or not they are attending school or taking a program of vocational training – who would otherwise be within the scope of eligibility of a dependent child as defined under title IV of the Social Security Act. This provision was included in order to provide assurance that children under the age of 21 will have their medical needs met if they are either a member of a family receiving a money payment under title IV of the Social Security Act or a member of a family which has the need and other characteristics described under title IV." S. Rep. No. 89-404, at 82 (1965). In addition, Congress gave states the option to provide Medicaid to all children under age 21 with incomes too high to meet the financial eligibility standards of AFDC, but too low to cover their health care costs. Social Security Act Amendments of 1965 §§ 1902(a)(10)(B), 1905(a). Although

[7] This requirement went into effect on July 1, 1967.

the Commissioner characterizes coverage of children ages 19 and 20 as a fundamental change to the Medicaid program, these provisions make clear that Congress designed Medicaid to cover low-income children under age 21. *See* Pet'r's Br. 33.[8]

It was not until 1981 that Congress, in an effort to achieve cost savings to the federal government, allowed states to exclude from Medicaid coverage children under age 21who were not receiving AFDC because of their age. *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35 § 2172, 95 Stat. 357, 808 (amending 42 U.S.C. §§ 1396d(a)(i), 1396a(b)(2)); Miscellaneous Revenue Act of 1981, Pub. L. No. 97-248 § 137(a)(7), 96 Stat. 324, 377-78 (1982) (amending 42 U.S.C. § 1396a(10)(A)). In 1991, Maine took up the option to cover children ages 19 and 20 who met the financial eligibility standards of their AFDC state plan. Me. Dep't of Health and Human Servs., Medicaid State Plan Amendment No. 91-14 (1991). Fourteen other states also covered this population before the ACA went into effect. Pet'r's Br. 4.

[8] The Commissioner's characterization is based on the inaccurate assertion that states have never before been required to cover individuals ages 19 and 20. *See, e.g.*, Pet'r's Br. 23, 33.

B. Two Years After Creating Medicaid, Congress Required State Medicaid Programs to Provide Comprehensive Benefits to Children Under Age 21

As enacted, Medicaid required that states that chose to participate in the program cover a minimum scope of benefits, including hospital and nursing facility services, laboratory and X-ray services, and physicians' services. States had the option to cover additional benefits, such as preventive screening services, dental services, and prescription drugs. Social Security Act Amendments of 1965, Pub. L. No. 89-97, §§ 1902(a)(13), 1905(a), 79 Stat. 286, 345-46, 351. Congress, however, became concerned that children with disabilities or with health problems that could lead to chronic illness and disabilities were not receiving treatment. *See* H.R. Doc. No. 90-54, at 7-8 (1967) (message from President Johnson recommending EPSDT to Congress); Dep't of Health, Ed., and Welfare, Soc. and Rehab. Serv., Med. Servs. Admin., MSA-PRG-21, Medical Assistance Manual 5-70-20 (1972). Consequently, Congress amended Medicaid to require that states provide a comprehensive array of services, known as "early and periodic screening, diagnostic, and treatment" (EPSDT) services, to Medicaid enrollees under age 21. *See* Social Security Act Amendments of 1967, Pub. L. No. 90-248, §§ 224, 302, 81 Stat. 821, 902, 929 (then codified at 42 U.S.C. § 1396a(a)(13)).

In adding EPSDT to the Medicaid program, Congress made a clear distinction between the health needs of children under age 21 and those of adults,

mandating that states take aggressive action to detect and treat children's health problems. *See* Dep't of Health, Ed., and Welfare, *supra*, at 5-70-20. The regulations implementing EPSDT directed states to locate facilities available to provide EPSDT services to children and to make the services available to Medicaid enrollees. Early and Periodic Screening, Diagnosis, and Treatment of Individuals Under Age 21, 36 F.R.21409-10 (Nov. 9, 1971) (then codified at 42 C.F.R. § 249.10). Moreover, the regulations made clear that states could provide EPSDT services to children under age 21 without providing those services to adults. *Id*.

Congress has maintained its focus on children under age 21, enhancing and strengthening EPSDT over time. In 1989, Congress defined EPSDT services in statute to include screening, vision, hearing, and dental services, as well as treatment services needed to "correct or ameliorate" defects, illnesses, and conditions discovered during a screening. States must provide these services to children under age 21 even if the services are not available to adults under the state plan. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, § 6403, 103 Stat. 2106, 2263-64 (adding 42 U.S.C. § 1396d(r) and amending § 1396a(a)(43)); *See also Rosie D. ex rel. John D. v. Swift*, 310 F.3d 230, 232 (1st Cir. 2002) (explaining the effect of the 1989 amendments). Congress later added a pediatric vaccine distribution program to EPSDT. *See* Omnibus Budget

Reconciliation Act of 1993, Pub. L. No. 103-66, § 13631, 107 Stat. 312, 636-45 (adding 42 U.S.C. § 1396s).

III. Since 1965, Congress Has Used Maintenance of Effort Requirements That Have Preserved Children's Access to Medicaid and Other Public Benefits

Since Medicaid began, Congress has used maintenance of effort requirements in both Medicaid and related public benefits programs. The requirements have protected low-income individuals from losing all or part of their medical or other public assistance. Maintenance of effort provisions enacted in 1965, 1986, and 1988 illustrate this common practice. Several of these provisions gave the federal agency administering Medicaid the authority to deny part or all of its Medicaid funding to a state that fails to adhere to the requirements. Nothing about the maintenance of effort provision in the ACA departs from this precedent.

1965: Congress included two maintenance of effort provisions in the legislation that created the Medicaid program. The first provision prohibited the Secretary from approving a Medicaid state plan if the operation of the plan would result in a reduction in aid or assistance provided under one of the five cash assistance programs related to Medicaid eligibility, including AFDC. Social Security Act Amendments of 1965, Pub. L. No. 89-97, §1902(c), 79 Stat. 286, 348. Congress directed the agency administering Medicaid to withhold all federal Medicaid funding from a state that violated the maintenance of effort requirement. The second provision gave the Secretary the authority to reduce federal

contributions to a state between 1965 and mid-1969 in rough parity to the amount that a state decreased its own contributions to Medicaid and other public benefits. *See id.* § 405.

1986: Beginning in 1984, Congress made a series of adjustments to the Medicaid statutes that expanded eligibility for children and pregnant women. Before 1984, states were required to cover children and pregnant women receiving cash assistance through AFDC. After three separate amendments to the Medicaid statutes between 1984 and 1986, states were required to cover children under age five and pregnant women who met the financial eligibility standards for AFDC. States had the option to cover groups of children under age five and pregnant women with incomes that exceeded the financial eligibility standards for AFDC. *See* Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2361, 98 Stat. 494, 1104 (codified at 42 U.S.C. §§ 1396d(n), 1396a(a)(10)(A)(i)(III); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9501, 100 Stat. 82, 201 (amending 42 U.S.C. § 1396d(n)(1)); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 1874, 2050 (codified at 42 U.S.C. §§ 1396a(l), 1396a(a)(10)(A)(ii)). In passing these changes to Medicaid, Congress took care to protect low-income children whose Medicaid eligibility was tied to AFDC. States that did not keep AFDC payment levels at their 1986 standards could not receive federal funding to cover optional children and pregnant women.

Omnibus Budget Reconciliation Act of 1986 § 9401(b) (adding 42 U.S.C. § 1396a(l)(4)(A)).

1988: In 1988, Congress began to transform the optional coverage of these groups into a requirement, with financial eligibility tied to the federal poverty level instead of AFDC. The legislation used two maintenance of effort provisions that preserved AFDC recipients' access to benefits. The first provision prohibited the Secretary from approving a state Medicaid plan if the state dropped AFDC payment levels below their 1988 standards. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302(c)(1), 102 Stat. 683, 752 (adding 42 U.S.C. § 1396a(c)(1)), repealed by Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 114(d), 110 Stat. 2105, 2180. As it had done in 1965, Congress directed the federal agency administering Medicaid to withhold all federal Medicaid funding from a state that did not meet the requirement.[9] Under the second provision, states that reduced AFDC payment levels below their 1987 standards could not receive federal funding to cover optional pregnant women and children. *See* Medicare Catastrophic Coverage Act

[9] In *Stowell v. Ives*, 976 F.2d 65, 69 (1st Cir. 1992), this court concluded that the maintenance of effort provision did not impose an obligation on states, but rather gave states a choice between maintaining AFDC payment levels (and retaining eligibility for federal Medicaid funding) and reducing AFDC payment levels (and jeopardizing eligibility for federal Medicaid funding). This court noted that "there is nothing unreasonable about Congress's choosing to work its will in this way." *Id*.

of 1988 § 302(c)(3) (amending 42 U.S.C. § 1396b(i)), repealed by Personal Responsibility and Work Opportunity Reconciliation Act of 1996 §114(d).

2010: Congress enacted the ACA in an effort to reduce the number of uninsured Americans. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care Education and Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (amending Pub. L. No. 111-148). Congress included a maintenance of effort provision in the ACA that is similar to those enacted in 1965 and 1988. If a state adopts eligibility standards more restrictive than those in effect on March 23, 2010 (the date Congress passed the ACA), the state cannot receive federal funding for its Medicaid program.[10] Patient Protection and Affordable Care Act § 2001(b) (amending 42 U.S.C. § 1396a(a) and adding §1396a(gg)). With respect to children under age 19, as well as children over age 19 if the state has elected to cover them, the maintenance of effort requirement continues through September 30, 2019. *Id.* The ACA contains a similar maintenance of effort provision that applies to the Children's Health Insurance Program (CHIP), which provides coverage to children with incomes too high to participate in Medicaid but too low to afford private health insurance. This provision also continues through September 30, 2019. *Id*. § 2101(b) (amending 42 U.S.C. § 1397ee(d)).

[10] The procedure that CMS must follow to withhold federal funding is set forth at 42 C.F.R. § 430.35.

CONCLUSION

In Maine, low-income children ages 19 and 20 depend on Medicaid to meet their significant health care needs. Despite the Commissioner's characterization of the ACA maintenance of effort provision as a "basic change in the Medicaid program," Congress designed Medicaid to cover low-income children under age 21 and has continued to focus on this population over time. Congress has long used maintenance of effort provisions that have encouraged states to continue to provide vulnerable individuals, including children under age 21, with access to Medicaid and other public benefits. The current maintenance of effort provision does not depart from this precedent. The court should rule in favor of the Respondent and uphold the maintenance of effort provision in the ACA.

Dated: August 11, 2014

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(a)(7)(B) and 29(d), and that the total number of words in this brief is 4904 words, according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

Dated: August 11, 2014

/s/ Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I hereby certify that on August 11, 2014, I electronically filed the foregoing document with the United States Court of Appeals for the First Circuit by using the CM/ECF system. I certify that the following parties or their counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system:

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