Nos. 11-11021 & 11-11067

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

State of Florida, by and through Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees/Cross-Appellants,
v.
United States Department of Health and Human Services, et al.,
Defendants-Appellants/Cross-Appellees.

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

BRIEF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS, AMERICAN PUBLIC HEALTH ASSOCIATION, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, FLORIDA PEDIATRIC SOCIETY/FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, FAMILIES USA, FLORIDA COMMUNITY HEALTH ACTION INFORMATION NETWORK, FLORIDA LEGAL SERVICES, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES, UNITED CEREBRAL PALSY, NATIONAL ALLIANCE ON MENTAL ILLNESS, NATIONAL DISABILITY RIGHTS NETWORK, DISABILITY RIGHTS FLORIDA, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW SUPPORTING DEFENDANTS-APPELLANTS/CROSS-APPELLEES AND FAVORING AFFIRMANCE OF SUMMARY JUDGMENT FOR DEFENDANTS ON COUNT IV OF THE SECOND AMENDED COMPLAINT

Jane Perkins*
Sarah Jane Somers
National Health Law Program
101 E. Weaver St., Ste. G-7
Carrboro, NC 27510
(919) 968-6308

Mark Regan
Disability Law Center of Alaska
3330 Arctic Blvd., Suite 103
Anchorage, Alaska 99503
(907) 565-1002

* Counsel of record

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1(b) of the Rules of the Eleventh Circuit Court of Appeals, counsel for *amici curiae* hereby state that none of the *amici* have parent corporations nor does any publicly held corporation own stock in any *amici*.

Pursuant to Rule 26-1, counsel further certifies that the Amended Certificate of Interested Persons contained in the Brief for Appellants is a complete list of persons and entities having an interest in the outcome of this case, with the addition of the following *amici curiae*: United Cerebral Palsy and Florida Legal Services. Also, the Florida Advocacy Center for Persons with Disabilities, listed at C-11 of Appellants' Amended Certificate, has changed its name to Disability Rights Florida.

TABLE OF CONTENTS

TABLE OF CITATIONS

CASES

STATUTES, LAWS, AND REGULATIONS

OTHER AUTHORITIES

INTEREST OF THE AMICI

Amici are national and Florida-based health care provider and consumer organizations that have worked with the Medicaid program over its 46-year history. While each *Amicus* has particular interests in the Medicaid program, they collectively bring to the Court an in-depth understanding of how the Medicaid Act has been amended and/or implemented over time. The parties have consented to the filing of this Brief.

Founded in 1930, the American Academy of Pediatrics (AAP) is a national, non-profit organization dedicated to furthering the interests of children's health and the pediatric specialty. The majority of people who are covered by Medicaid are children, and pediatricians interact with Medicaid more than any other leading physicians' society. Established in 1872, the American Public Health Association (APHA) aims to protect families and communities from preventable, serious health threats and strives to assure that community-based health promotion and disease prevention activities and preventive health services are universally accessible. APHA represents a broad array of health professionals and others who care about the health of their communities, many of whose residents are uninsured or depend on Medicaid for their health care. The National Association of Community Health Centers (NACHC) is the membership organization for federally qualified health centers (FQHCs). There are more than 1200 FQHCs with more than 7000 sites

serving 23 million patients nationwide. Approximately 35% of health center patients are Medicaid recipients; approximately 40% are uninsured. NACHC estimates that the Medicaid expansions contained in ACA will result in health centers serving approximately 18.4 million Medicaid recipients by 2015. The Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics (FPS) is a non-profit professional organization of pediatricians and pediatric specialists. In the most recent Federal fiscal year, more that 1.6 million children were enrolled in Florida's Medicaid program. A substantial proportion of FPS's approximately 2100 members are enrolled as Medicaid providers in Florida and provide primary care and specialty services to children enrolled in Florida's Medicaid program.

Families USA is the national organization for health care consumers. For the past 28 years, Families USA has led various coalition efforts designed to expand health coverage for low-income families, including the National Medicaid Coalition that it chairs. Florida Community Health Action Information Network (CHAIN) is a statewide consumer health care advocacy organization. Priorities of Florida CHAIN include ensuring that Medicaid beneficiaries are protected against barriers to access and working to obtain coverage for Florida's estimated 4.1 million uninsured. Florida Legal Services, Inc. (FLS) is a statewide nonprofit law firm founded in 1973 to expand the availability of legal assistance to the poor. As

a state support center for over 40 legal aid/legal services offices throughout Florida, FLS works with low income Floridians who are in desperate need of health care services. Florida has the third highest rate of uninsurance in the U.S.

The National Partnership for Women and Families is a nonprofit, nonpartisan organization that uses public education and advocacy to promote access to quality, affordable health care, work and family policies, and fairness in the workplace. Medicaid is a particularly vital source of health care for women of reproductive age (15-44).

United Cerebral Palsy (UCP) is one of the oldest and largest national health organizations dedicated to improving the lives of people with disabilities, many of whom receive services pursuant to the Medicaid program. Founded in 1949, the organization advances the independence, productivity and full citizenship of people with disabilities through a nationwide network of approximately 100 affiliates across the country. The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. Founded in 1979, NAMI has over 1100 state and local affiliates that engage in research, education, support, and advocacy. The National Disability Rights Network (NDRN) is the non-profit membership association of protection and advocacy (P&A) agencies that are located in all 50 States, the District of Columbia, Puerto Rico, and the U.S.

Territories. For 30 years, P&As have worked with children and adults with disabilities who depend on Medicaid-funded services and supports to enable them to live in the community rather than in institutions. Disability Rights Florida, formerly the Advocacy Center for Persons with Disabilities, is the designated P&A for the State of Florida. In 2009, Florida Disability Rights assisted approximately 7,500 Floridians, with the largest group of requests for assistance in the area of securing access to health care supports and services. The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advocate for the rights of individuals with mental disabilities.

No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici* and *amici*'s counsel, contributed money intended to fund preparation or submission of this brief.

STATEMENT OF THE ISSUE PRESENTED

Whether the district court properly held that the Medicaid provisions of the Patient Protection and Affordable Care Act (ACA) do not impermissibly coerce the Plaintiff States or commandeer their Medicaid programs.

SUMMARY OF THE ARGUMENT

Count Four of the Second Amended Complaint challenged provisions of the Patient Protection and Affordable Care Act (ACA) that expand Medicaid to

childless, non-disabled adults whose incomes are below 133% of the federal poverty level. Second Am. Compl. at ¶¶ 83-86. Part of the State Plaintiffs' "coercion and commandeering" claim was that the ACA works such a transformation in Medicaid that the States have no choice but to spend money and provide services in ways that are "radically changed" from what was required by the Medicaid Act on the day before the ACA was enacted. Mem. in Supp. of Pls' Mot. for Summ. J. (Plfs. Mem.) at 25. According to the Plaintiffs, the Act converts Medicaid into a "federally-imposed universal healthcare regime" that they have no choice but to accept. One can expect the States to reiterate their coercion and commandeering assertions before this Court.

The Court need not reach the merits of Plaintiffs' complaints about how the ACA changes Medicaid. It can join the five Circuits and the district court below—all of which have held that a "coercion" claim does not lie against a Spending Clause cooperative-federalism program when, as here, a State has the legal right to withdraw from the program.[1] If, however, the Court does decide to address the

[1]Over half of the Plaintiff States' Federal appellate courts have rejected application of the coercion theory (Alaska, Arizona, Colorado, Idaho, Iowa, Kansas, Maine, Nebraska, Nevada, North Dakota, South Dakota, Utah, Washington and Wyoming). *See State of Fla. ex rel. Bondi v. U.S Dep't of Health & Human Servs.,* No. 3:10-cv-91, 2011 WL 285683, at *5 (N.D. Fla. Jan. 31, 2011) (Docket # 150 at 10) (collecting cases). Fifteen States did not submit evidence of the specific impact of the Medicaid provisions (Alabama, Alaska, Colorado, Idaho, Iowa, Kansas, Maine, Michigan, Mississippi, Ohio, Pennsylvania, South Carolina, Washington, Wisconsin, and Wyoming). The Alaska, Colorado, Idaho, Iowa,

nature of the changes that the ACA makes in Medicaid, it will find that the Plaintiffs' coercion and commandeering claims find no support in the history and structure of the Medicaid Act, as originally enacted or as Congress and the States have changed it over time.

ARGUMENT

Medicaid is part of the Social Security Act, enacted pursuant to Congress's Spending Clause authority. *See* 42 U.S.C. §§ 1396-1396w-1. From the time it was enacted, Medicaid has conditioned federal funding on States' agreements to comply with a series of mandates. The Supreme Court has consistently recognized Congress's broad authority to enact such legislation pursuant to the Spending Clause. In *South Dakota v. Dole*, the Court held that cooperative-federalism programs such as Medicaid, where States accept Federal money together with Federal conditions for how that money may be used, are constitutional. 483 U.S. 203, 107 S.Ct. 2793 (1987). *See also, e.g., Okla. v. Civil Serv. Comm'n,* 330 U.S. 127, 67 S.Ct. 544 (1947) (affirming Congress's broad power to set conditions for the receipt of Federal funds); *Steward Mach. Co. v. Davis*, 301 U.S. 548, 57 S.Ct. 883 (1937) (affirming Congress's authority under taxing and spending clauses to enact Social Security Act); *Sabri v. United States*, 541 U.S. 600, 124 S.Ct. 1941

Kansas, Maine, Washington, and Wyoming Plaintiffs are, thus, seeking relief on a claim that has been rejected by their Federal courts of appeals and that they have not supported with factual attestations.

(2004) (unanimously reaffirming broad scope of Congress's spending power); *cf. Harris v. McRae*, 448 U.S. 297, 100 S.Ct. 2671 (1980) (holding Congress's ability to refuse to provide Medicaid funds necessarily involves the ability to subsidize only certain procedures and to exclude even medically necessary abortions from those covered procedures).[2]

I. The Affordable Care Act Does Alter Medicaid's Structure or Purpose.

A. Medicaid's Core Framework

Medicaid was added to the Social Security Act in 1965 as Title XIX. Congress invited States to accept significant Federal funding—half or more of State expenditures—in return for providing coverage for specific groups of people (additional groups at State option) for a specific set of services (additional services at State option). Since 1965, Congress has amended Medicaid on numerous

[2] In considering this issue, the District Court cited Lynn A Baker, *The Spending Power and the Federalist Revival*, 4 CHAP. L. REV. 195 (2001), which argues that conditional Federal spending programs operate to allow politically powerful states to oppress less powerful states. That was not the argument being made by the States here. Indeed, the Plaintiffs include officials from Alaska, Idaho, North Dakota, and South Dakota, which are among the states receiving the most per capita benefit from transfers of federal dollars. *Id.* at 211-12. Also, Professor Baker does not explain how the coercion theory should be applied in cases such as this one. *Cf.* Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345,372-78 (Dec. 2008); Brian Galle, *Federal Grants, State Decisions*, 88 B. U. L. REV. 875, 919 (Oct. 2008) ("The difficulty is that Baker sees coercion in virtually every federal-state exchange."); Robert T. Bull, *The Virtue of Vagueness, A Defense of South Dakota v. Dole*, 56 DUKE L. J. 279, 293-300 (Oct. 2006).

occasions. Whenever these changes have occurred, including those in the ACA, they have not altered the program's essential framework.

First, Medicaid is a means-tested program that provides health insurance coverage to people who generally cannot afford to purchase private health insurance. The Medicaid Act does not establish a "government run" health system but rather is an insurance coverage program that enables enrolled individuals to gain access to private health care providers, including doctors, community health clinics, pharmacies, home health aides, hospitals, and nursing homes. Medicaid's purpose is achieved through a statutory structure that entitles eligible individuals to coverage for items and services collectively known as "medical assistance."[3]

[3] The ACA clarifies the meaning of "medical assistance." *See* ACA § 2304 (amending 42 U.S.C. § 1396d(a)). The clarification responds to some recent court decisions that limited medical assistance simply to payment of a provider claim when and if it was submitted. *E.g. Okla. Ch. of Am. Acad. of Ped. v. Fogarty*, 472 F.3d 1208, 1213-14 (10th Cir. 2007) (refusing to follow *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998)). As Congress made abundantly clear, the clarification was made to "correct any misunderstanding" and "to conform th[e] definition to the longstanding administrative use and understanding of the term" prior to these recent cases. *See* H.R. Rep. No. 111-299, 1st Sess., at 649-50, 2009 WL 3321420 (Leg. Hist.) (Oct. 14, 2009); *see also* 156 Cong. Rec. H1854, 1856, 2010 WL 1006359 (Mar. 21, 2010) (statement of Rep. Waxman) (explaining on the House floor the committee report's rationale for the clarification); *Id.* at H1891, 1967, 2010 WL 1027566 (Mar. 21, 2010). The clarification does not change the responsibilities States assume when they accept Federal funds, nor does it require States to directly provide medical services by establishing state-owned or operated facilities or employing providers. The clarification does, however, confirm that this Court properly applied the term when it decided *Doe v. Chiles* in 1998.

Second, the Medicaid Act creates an entitlement for States that ensures that all eligible expenditures qualify for federal funding at the appropriate federal matching rate. This State-Federal partnership of "cooperative federalism" represents an extraordinary commitment on the part of the Federal government, which picks up at least half of the States' costs of paying for health care services and administering the program. Federal funding for expenditures typically can range from 50-83%, with higher funding for States with lower per capita incomes—a feature designed to ensure that Federal funds flow to States with the greatest need. *See* 42 U.S.C. § 1396b(a). Federal funds cover at least 50% of the costs of State program administration, *id.* at § 1396b(a)(1), and, for some activities and services, 100% of the costs, *id.* at § 1396b(a) (providing full Federal funding for electronic health records development, immigrant status verification systems, and Medicaid services provided through the Indian Health Service).

Third, State participation in the Medicaid program is voluntary. States choosing to participate and receive Federal funding must submit a Medicaid plan to the U.S. Secretary of Health and Human Services. Once approved, a State must operate its program consistent with the Medicaid Act and regulations. *See, e.g., Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 2513 (1990). And while Federal payments have always come with strings attached, an unwilling State can opt out by withdrawing its Medicaid plan. *See, e.g., Doe v. Chiles*, 136

F.3d 709, 722 (11th Cir. 1998) (noting Medicaid is a Spending Clause program where Florida "always retains th[e] option" to withdraw); *see* 42 U.S.C. § 1396b(a) (limiting Federal funding to States with an approved plan); 42 C.F.R. § 430.48 (regarding repayment if State terminates participation).[4]

Fourth, while different and changing obligations have been enacted over time, the Medicaid Act has always set a minimum floor of requirements while allowing States a great deal of flexibility in how to attain the floor and/or exceed it, including with respect to the amount and mix of services they will cover, provider payments, and procedures regarding eligibility and enrollment. Indeed, a hallmark of the Medicaid program is the considerable discretion that States are given to tailor their Medicaid programs and, thus, there is considerable variation of Medicaid programs from State to State. Finally, as with other Spending Clause enactments, Congress and the States have used Medicaid not simply as a funding mechanism to help poor, elderly, and medically indigent Americans but also to address broader national concerns, such as reducing infant mortality, improving childhood immunization rates, and encouraging community-based alternatives to institutional long-term care.

[4] As Judge Vinson recognized, the States know they can terminate participation in Medicaid. *See State of Fla. ex rel. Bondi*, No. 3:10-cv-91, 2011 WL 285683, at *4 (N.D. Fla. Jan. 31, 2011) (Docket # 150 at 9) (citing declarations from state Medicaid officials from Nevada and South Dakota).

B. Medicaid's Consistent Structure Over Time

The intrinsic framework described above has held true for the 46-year history of the Medicaid program, as illustrated by the following legislative reforms, including the ACA:

1965: The Medicaid Act was enacted to offer States the option to participate in a Federal-State partnership designed to improve the health access and status of poor and disabled Americans. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, § 121 (adding Title XIX, 42 U.S.C. § 1396). Participating states were required to make medical assistance available to low-income residents who were receiving public cash assistance—Aid to Families with Dependent Children (AFDC), Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. *See* 42 U.S.C. § 1396a(a)(10)(A). From this eligibility floor, States were given options to make medical assistance available to families and people with disabilities whose incomes were too high to qualify for public cash assistance. *See Id.* at § 1396a(a)(10)(B), (C).

Likewise, participating States were required to cover a minimum scope of benefits, primarily hospital and nursing facility services, laboratory and X-ray services, and physicians' services. *Id.* at §§ 1396a(a)(13), 1396d(a)(1)-(5). States could also receive Federal funding for a number of other, mostly non-acute, often community-based services, including outpatient prescription drugs, preventive

screening services for children, and dental and home health services. *Id.* at §§ 1396d(a)(6)-(15). In addition to the eligibility and service mandates and options, the new law included protections for consumers and participating providers. For example, participating States needed to assure the Federal government that medical assistance would be furnished with "reasonable promptness to all eligible individuals," *id.* at § 1396a(a)(8), and that enrollees would receive due process when claims were denied, *id.* at § 1396a(a)(3).

Thus, the original Medicaid Act was framed to include minimum Federal requirements governing who was to be covered and what sorts of services they would receive, along with a variety of State options to exceed the Federally-mandated floor. In addition, the law required some protections in the manner by which people qualified for and received services and how participating providers were to be treated. These provisions remain an integral part of the Medicaid program today and have not been changed by the ACA.

1967: Congress amended the Act to require States to cover previously optional early and periodic screening, diagnostic and treatment (EPSDT) services for Medicaid-eligible children under age 21. *See* Social Security Act Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821, §§ 224, 302 (amending then effective version of 42 U.S.C. § 1396a(a)(13)). Through EPSDT, the Federal and State partnership evolved to cover well-child examinations; vision, hearing and dental

care; vaccines, and services needed to address health problems. Thus, the service floor was lifted, and all States now cover EPSDT.[5]

1972: Although Medicaid began by confining its minimum eligibility requirements to standards set by state cash welfare programs—which did and still do vary dramatically from State to State—it soon changed to provide some nationwide eligibility standards for elderly people and people with disabilities. Seven years after Medicaid's enactment, the Social Security Act Amendments of 1972 established Supplemental Security Income (SSI), a single Federal cash assistance program for low-income elderly people and people with disabilities that replaced previously State-operated cooperative-federalism programs. *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, §§ 301 (replacing Title XVI of the Social Security Act) and § 209(b) (described below); *see also* Pub. L. No. 93-233, § 13 (conforming amendment to 42 U.S.C. § 1396a(a)(10)(A)). Congress encouraged States to extend Medicaid to everyone who was eligible for the newly-enacted SSI program. However, concerned that some States might exercise their right to terminate participation in the Medicaid

[5] Congress has maintained focus on improving the health of low-income children. For example, EPSDT coverage has been clarified, *see* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, § 6403 (adding 42 U.S.C. § 1396d(r) and amending § 1396a(a)(43)), and strengthened to include a Federally funded pediatric vaccines program, *see* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, § 13631 (adding 42 U.S.C. § 1396s).

program rather than implement the mandatory expansion, Congress gave States the option to provide Medicaid to only those people who would have been eligible for Medicaid under a State's prior State Medicaid plan. *See* 42 U.S.C. § 1396a(f) (also called 209(b)). *See* S. Rep. 93-553, 93rd Cong., 1st Sess. 55-57 (1973); *see also Schweiker v. Gray Panthers*, 453 U.S. 34, 38-39 & nn. 3-6, 101 S.Ct. 2633, 2637-38 & nn. 3-6 (1981). Also, all States maintained flexibility to cover people with disabilities whose incomes exceeded the SSI limits.[6] Notably, the ACA's Medicaid coverage for childless adults uses a national financial eligibility standard, just as Congress did in 1972 for elders and people with disabilities.

1981: In 1981, the Federal government revised coverage of long term care services in Medicaid, which were focused on institutional care, to encompass home and community-based care. *See* Omnibus Budget and Reconciliation Act (OBRA) of 1981, Pub. L. No. 97-35, § 2176, 95 Stat. 357, § 2176 (codified at 42 U.S.C. § 1396n(c)). States that elected to move their programs in the direction of community integration were required to adhere to coverage and service conditions, which, if satisfied, would result in expanded Federal funding to cover both medical

[6] All 26 of the Plaintiff States now cover, as a matter of state option, at least some elderly people or people with disabilities with incomes up to or above 300% of the SSI level—which is about 224% of Federal poverty level. *See* NCHSD, *State Medicaid Buy-In Program—Fourth Quarter 2008*, at http://www.nchsd.org/libraryfiles/MBI/MBI_Summaries_Q4_2008.pdf; Kaiser Family Found., *2009 Comparison Charts*, at http://www.statehealthfacts.org/comparereport.jsp?rep=60&cat=4 and http://www.statehealthfacts.org/comparemaptable.jsp?ind=817&cat=4.

and non-medical services and supports. Enrollees who needed an institutional level of care could receive these services in the community if the State provided necessary assurances to the Federal government that the coverage would be cost-effective and that people's health and welfare would be protected. *Id*. Yet again, the Medicaid Act was amended to enhance State flexibility while maintaining underlying Federal standards aimed at improving the welfare of elderly people and people with disabilities. Indeed, State community-based care innovation has flourished, but under comprehensive Federal standards.

1984-90: Between 1984 and 1990, Congress enacted legislation that in fundamental respects parallels the ACA's extension of coverage to poor adults. Over this time period and through a series of incremental reforms, Congress established a national floor of coverage for children and pregnant women. This floor is accompanied by State options to reach further, but a solid floor remains, nonetheless. Certain reforms that began as options ultimately became mandatory, as follows:

Prior to 1984, as noted above, participating States were required to extend Medicaid to children and pregnant women receiving cash assistance through the AFDC program. States were given the option to extend coverage to children, including unborn children, with AFDC-level income but living in families that did not qualify for cash assistance, typically because of the presence of two parents in

the household. In 1984, this optional coverage was made mandatory for children under age five and first-time pregnant women who met the financial eligibility standards for the State's AFDC program. *See* Deficit Reduction Act (DRA) of 1984, Pub. L. No. 96-369, 98 Stat. 494, § 2361 (adding 42 U.S.C. §§ 1396d(n) and 1396a(a)(10)(A)(i)(III)). In 1985, States were required to cover all pregnant women who met the financial eligibility criteria for AFDC. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, § 9501 (amending 42 U.S.C. § 1396d(n)). A year later, the Medicaid Act was amended to give States the option to cover pregnant women and young children with low family incomes that nevertheless exceeded AFDC payment levels. *See* OBRA of 1986, Pub. L. No. 99-509, 100 Stat. 1874, § 9401 (adding 42 U.S.C. §§ 1396a(l), 1396a(a)(10)(A)(ii)(IX)).

In 1988, these options began to be transformed into requirements, through phased in coverage tied to the Federal poverty level, rather than the AFDC program. Coverage ultimately reached all children, birth to age 5, and pregnant women with family incomes under 133% of the federal poverty level and, in the case of children aged 5-18, with family incomes under 100% of the poverty level. *See* Medicare Catastrophic Coverage Act of 1988 (MCCA), Pub. L. 100-360, 102 Stat. 683, § 302 (adding 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(2)(A)(iii)); OBRA of 1989, Pub. L. 101-239, 103 Stat. 2106, § 6401 (amending 42 U.S.C. §§

1396a(a)(10)(A)(i), 1396a(a)(A)(10)(A)(ii), 1396a(l)); OBRA of 1990, Pub. L. 101-508, 104 Stat. 1388, § 4601 (same). During this time, Congress allowed States, as it had during the previous 25 years, to extend benefits to needy children and pregnant women with incomes above the minimum coverage floors. *Id.*[7]

Additionally, to facilitate enrollment of these populations, the 1990 Congress required States to assure that their Medicaid applications would be accepted not only at welfare offices but also at health care sites frequented by children and pregnant women, such as community health centers and hospitals. 42 U.S.C. § 1396a(a)(55) (added by OBRA of 1990, § 4602)). Beyond this requirement, the Act permitted States to allow Medicaid-participating providers to make "presumptive eligibility" determinations and obtain Federal funding for services at the earliest possible time and without penalty if the child or woman was later found not to be Medicaid eligible. *See* 42 U.S.C. §§ 1396r-1 (optional presumptive eligibility for pregnant women, added in 1986); 1396r-1a (optional presumptive eligibility for children, added in 1997).[8]

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[7] Twenty-two of the Plaintiff States–all but Alabama, North Dakota, Utah and Wyoming–provide, as a matter of state option, Medicaid coverage for at least some groups of children or pregnant women that exceeds the 100%/133% Federal poverty-level minimums. *See* Kaiser Family Found., *2011 Comparison Charts, at* http://www.statehealthfacts.org/comparereport.jsp?rep=77&cat=4, http://www.statehealthfacts.org/comparereport.jsp?rep=76&cat=4, and http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4.

[8] *Compare* 42 U.S.C. § 1396r-1(k) (optional presumptive eligibility for childless adults, added by ACA § 2001(a)(4) (eff. 2014)).

At the same time, Congress and the States addressed eligibility floors for low-income elderly and disabled people, once again beginning with options that later were transformed into basic requirements, with flexibility for States regarding how these requirements would be achieved and to offer more than was minimally required. For example, lower-income elderly people and people with disabilities who were eligible for Medicare typically needed help to meet that program's costs, including monthly Medicare Part B premiums. In 1986, Congress created a new Medicaid option through which States could receive federal payments toward coverage of Medicare cost-sharing for people whose incomes were at or below a State-specified threshold at or below the poverty line. *See* OBRA of 1986, § 9403 (adding 42 U.S.C. §§ 1396d(p), 1396a(a)(10)(E)). Two years later, Congress converted the option into a requirement for States to phase in coverage of at least Medicare premiums and cost-sharing for all persons with incomes below 100% of poverty. *See* MCCA, § 301 (amending 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(p)). Then, two years later, Congress required States to phase in Medicare cost-sharing for people with family incomes up to 120% of the poverty line, with the phase-in to be fully effective by 1995. *See* OBRA of 1990, § 4501. Finally, in § 4732 of the Balanced Budget Act of 1997, Pub. L. 105-33, Congress created the "Qualified Individual" program, through which most states provide cost-sharing assistance to Medicare beneficiaries with incomes up to 135% of poverty. Before this, President

Reagan had developed and Congress had enacted an option for States to ignore parental income of any amount and provide Medicaid to disabled children in their homes rather than institutions. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, § 134 (adding 42 U.S.C. § 1396a(e)(3)).

1993–2008: There is also ample precedent for Medicaid coverage of childless adults prior to enactment of the ACA. Since Medicaid's inception, States have been authorized to obtain Federal funding to implement Medicaid demonstration projects. *See* 42 U.S.C. § 1315. States began to use this option in the mid 1990s to extend Medicaid coverage to childless, nondisabled adults whose incomes fall below a State-set percentage of the poverty level: This is precisely the population group assisted by the ACA. By 2008, 18 States had received Federal permission to extend coverage to childless, nondisabled adults using Federal Medicaid funds, including Arizona, Idaho, Indiana, Iowa, Maine, Michigan, and Utah. *See* Keavney Klein & Sonya Schwartz, Nat. Acad. for State Health Pol., *State Efforts to Cover Low-Income Adults Without Children* 3 (Sept. 2008).

2010: In the context of covering America's uninsured, the ACA's Medicaid provisions are a step towards better health care coverage and better health for low-income people, and this is just another step along the same path Medicaid has followed for the past 46 years.

Simplified rules for who is eligible, with no requirement to apply for public cash assistance in order to get health care. Over time, Medicaid has provided coverage to low-income children, pregnant women, elders and people with disabilities on the basis of their incomes, not their receipt of public welfare cash assistance. For more than 15 years, all States have been required to provide coverage for young children and pregnant women whose family incomes are at or below 133% of the poverty level, and for more than 10 years, most States have been required to provide coverage for Medicare beneficiaries with family incomes below 135% of poverty. Now, beginning in 2014, the ACA adjusts the Medicaid eligibility floor so that States not already doing so will extend coverage to nondisabled adults with family incomes below 133% of the poverty level. *See* ACA § 2001. States have the option to implement the expansion early. As is typical for the Medicaid program, States retain options to provide additional coverage beyond the Federal floor. *Id.* As noted, all 26 of the State Plaintiffs have provided coverage for at least some adults whose family incomes exceed 133% of poverty, while 22 of the 26 States have provided coverage for children and pregnant women whose family incomes exceed that level.

Federal consideration for State budgets. The ACA contains exceptionally generous Federal funding to cover the costs associated with expanding coverage. At its outset in 2014, the improved Medicaid access will be entirely Federally

funded. Even after State participation in funding is fully phased in by 2020, States will only be responsible for 10% of the costs associated with this group. *See* Health Care Education and Reconciliation Act, § 1201 (adding 42 U.S.C. § 1396b(y)(1)). Additionally, while the new law includes a "maintenance of effort" provision to discourage States from dropping coverage between now and 2014, there is an exception to this requirement for States that are in a "budget crisis." *See* ACA § 2001(b) (adding 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)).[9]

State options to cover additional home and community-based services. As noted above, Medicaid has always provided for a mix of mandatory and optional eligibility categories and mandatory and optional services and, since 1981, has included State options for covering additional home and community-based services. The ACA establishes several new State options to obtain Federal funds

[9] By comparison, the State and Federal governments typically made the Medicaid expansions of the 1970s and 1980s using the regular Medicaid matching rates. Moreover, there is nothing unprecedented in Congress's attempting to ensure that States maintain their Medicaid programs while the adult coverage is being phased in. Maintenance of effort provisions were utilized early on, *see* Social Security Act Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821, § 2214, and Congress and the States have followed this pattern on numerous previous occasions. *E.g.*, OBRA of 1986, § 9401(b) (adding 42 U.S.C. § 1396a(l)(4)(A)); Pub. L. No. 100-203, 101 Stat. 1330, § 4101(e)(4) (1987) (amending 42 U.S.C. § 1396a(l)(4)(A)). Nor is it unprecedented for there to be a link between States' maintenance of Medicaid efforts and enhanced Federal funding. *See* American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, § 5001(f) (2009) (making temporary, substantial increases in each State's Federal funding, but, "to prevent constrictions of income eligibility requirements," specifying that States would not get increases if they employed eligibility standards more restrictive than those in effect on July 1, 2008).

for dynamic, innovative programs for covering long-term care and home care for older people and people with disabilities. *See, e.g.,* ACA § 2401 (Community First Choice), ACA § 2403 (Money Follows the Person Rebalancing).

In sum, while altered over its history to improve health access for poor people, the Medicaid bargain remains much the same today, after passage of the ACA, as it was in 1965. The Medicaid Act continues to provide States an entitlement to Federal funding for administration and services provided through the Medicaid program. Participation is not compulsory. However, to participate, States must adhere to minimum federal floor requirements with respect to eligibility, services, and program administration. Beyond the floor, States have considerable discretion in how they will implement the Federal requirements and to decide whether to go beyond what the Federal law requires.[10]

[10] The District Court issued declaratory relief invalidating the entire ACA, including the Medicaid provisions, on the theory that otherwise constitutional provisions could not be severed from the unconstitutional individual mandate. The United States' arguments on this subject, Br. for Appellants at 55-60, fully apply to the ACA's Medicaid title. The Medicaid amendments are in Title II of the ACA, while the individual mandate is in Title I. The Medicaid amendments make changes in Title XIX of the Social Security Act, while the individual mandate itself involves an amendment to the Internal Revenue Code, with associated amendments to the Public Health Service Act. The Medicaid provisions independently promote Congress's purpose of making affordable coverage available to low-income Americans. As the Court noted in *New York v. U.S.*, 505 U.S. 144, 186, 112 S.Ct. 2408, 2434 (1992), "Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be

Conclusion

The Court should affirm the District Court's decision to grant the Defendants' Motion for Summary Judgment on Count Four of the Second Amended Complaint.

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Respectfully submitted,

American Academy of Pediatrics, American Public Health Association, National Association of Community Health Centers, Florida Pediatric Society/Florida Chapter of the American Academy of Pediatrics, Families USA, Florida Community Health Action Information Network, Florida Legal Services, National Partnership for Women and Families, United Cerebral Palsy, National Alliance on Mental Illness, National Disability Rights Network, Disability Rights Florida, Judge David L. Bazelon Center for Mental Health Law, by their counsel

_/s/_____
Jane Perkins*
Sarah Jane Somers

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frustrated." Moreover, it was not appropriate for the District Court to draw any inferences against severability from the fact that H.R. 3590, as it passed the Senate in December 2009 and then the House in March 2010, did not contain a severability clause. Order Granting Summary Judgment at 67-68; Order [Clarification and Stay] at 6. Contrary to the District Court's misreading of the legislative history, the Senate did not delete a severability clause from H.R. 3590 as originally received from the House: that bill, then labeled the Service Members Home Ownership Tax Act of 2009, did not contain a severability clause. S. 1796, the earlier Senate health reform bill from which the Senate derived much of the language Congress ultimately enacted, did not contain a severability clause either.

National Health Law Program
101 E. Weaver St., Suite G-7
Carrboro, NC 27510
(919) 968-6308
(919) 968-8855 (Fax)
perkins@healthlaw.org
somers@healthlaw.org

Mark Regan
Disability Law Center of Alaska
3330 Arctic Blvd., Suite 103
Anchorage, Alaska 99503
(907) 565-1002
(907) 565-1000 (Fax)
mregan@dlcak.org

* Counsel of Record

CERTIFICATE OF COMPLIANCE

I certify that this brief, prepared in 14 point Times New Roman font, complies with the type-volume limitation set forth in FRAP 32(a)(7)(B). This brief contains 5685 words.

_/s/_____
Jane Perkins

CERTIFICATE OF SERVICE

I hereby certify that on April 8, 2011, I filed the foregoing Amici Curiae Brief by causing paper copies to be delivered to the Clerk of Court by Federal Express and that, by agreement with the parties' counsel, I caused the Brief to be served by mail, first class postage pre-paid and electronic mail upon:

Thomas M. Bondy
Appellate Staff
Civil Division, Room 7531
Department of Justice
950 Pennsylvania Ave., N.W.
Washington, D.C. 20530-0001
Thomas.Bondy@usdoj.gov

David Boris Rivkin, Jr.
Lee Alfred Casey
Andrew Grossman
Baker & Hostetler LLP
1050 Connecticut Ave., N.W., Suite 1100
Washington, D.C. 20036
drivkin@bakerlaw.com
lcasey@bakerlaw.com
agrossman@bakerlaw.com

Carlos Ramos-Mrosovsky
Baker & Hostetler LLP
45 Rockefeller Plaza, 11th Floor
New York, New York 10111
cramosmrosovsky@bakerlaw.com

Larry James Obhof, Jr.
Baker & Hostetler LLP

1900 E. 9th Street, Suite 3200
Clevland, Ohio 44114
lobhof@bakerlaw.com

Blaine H. Winship
Scott Douglas Makar
Timothy David Osterhaus
Office of the Attorney General, Florida
The Capitol, Suite PL-01
400 South Monroe Street
Tallahassee, Florida 32399
blaine.winship@myfloridalegal.com
scott.makar@myfloridalegal.com
timothy.osterhaus@myfloridalegal.com

Katherine Jean Spohn
Office of the Attorney General, Nebraska
2115 State Capitol
Lincoln, Nebraska 68509
katie.spohn@nebraska.gov

William James Cobb III
Office of the Attorney General, Texas
209 W. 14th Street
Austin, Texas 78711
bill.cobb@oag.state.tx.us

Gregory Katsas
Jones Day
51 Louisiana Ave., N.W.
Washington, D.C. 20001-2105
ggkatsas@jonesday.com

__/s/_____
Jane Perkins