No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL.,
Petitioners,
v.
UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF NATIONAL HEALTH LAW PROGRAM, AMERICAN ACADEMY OF PEDIATRICS, ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, EASTER SEALS, INC., NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NATIONAL COUNCIL ON AGING AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (SUGGESTING AFFIRMANCE ON THE MEDICAID ISSUE)

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QUESTION PRESENTED

Whether the Eleventh Circuit Court of Appeals properly held that the Medicaid expansion provisions of the Patient Protection and Affordable Care Act do not impermissibly coerce Petitioner States into continuing their participation in the Federal-State cooperative Medicaid partnership.

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Harris v. McRae,
448 U.S. 297 (1980). 6

Helvering v. Davis,
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Okla. Ch. of Am. Acad. of Pediatrics v. Fogarty,
472 F.3d 1208 (10th Cir. 2007). 5

Oklahoma v. U.S. Civil Service Comm'n,
330 U.S. 127 (1947). 7

Steward Mach. Co. v. Davis,
301 U.S. 548 (1937). 6, 7

West Virginia v. U.S. Dep't of Health & Human Servs.,
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26 U.S.C. § 5000A(e)(2). 29

26 U.S.C. § 5000A(e)(5). 29

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42 U.S.C. § 1304. 9

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42 U.S.C. § 1395w-101-134. 22

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42 U.S.C. § 1396a(a)(13). 13

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42 U.S.C. § 1396r-1(e). 19

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42 U.S.C. § 1396u-5. 22

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42 U.S.C. § 1396u-5(c). 22

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Alaska Stat. § 47.07.020(b)(6). 32

Alaska Stat. § 47.07.020(b)(12). 32

Neb. Rev. Stat. § 68-915(8). 32

North Dakota Century Code § 50-24.1-02.7.. 32

155 Cong. Rec. S13803-04
(daily ed. Dec. 23, 2009).. 26

155 Cong. Rec. S13831
(daily ed. Dec. 23, 2009).. 26

156 Cong. Rec. H1854, H1856 (Mar. 21, 2010) 5

156 Cong. Rec. S2069
(daily ed. Mar. 25, 2010). 28

76 Fed. Reg. 21,950 (Apr. 19, 2011). 26

H.R. Rep. No. 92-231 (1971),
reprinted in 1972 U.S.C.C.A.N. 4986. 13

H.R. Rep. No. 99-727,
reprinted in 1986 U.S.C.C.A.N. 3689. 17

H.R. Rep. No. 111-299.. 5

Pub. L. No. 74-271.. 8

Pub. L. No. 81-734.. 9

Pub. L. No. 86-778.. 9

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Pub. L. No. 89-97.. . . . . 4, 8, 10, 12, 13, 19

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Pub. L. No. 101-508.. . . . . 18, 20

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Pub. L. No. 108-173.. 22

Pub. L. No. 111-5.. 23

S. Rep. No. 744, 90th Cong., 1st Sess. 169, *reprinted in* 1967 U.S.C.C.A.N. 3006. 8

S. Rep. No. 93-553 (1973). 15

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42 C.F.R. § 430.35(d)(1)(i). 7

42 C.F.R. § 430.48(b)(2). 6

42 C.F.R. § 430.60. 7

OTHER AUTHORITIES

James F. Blumstein & Frank L. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 Vand. L. Rev. 125 (2000). 22

Matthew Buettgens, Stan Dorn, & Caitlin Carroll, The Robert Wood Johnson Found. and Urban Inst., *Consider Savings as Well as Costs* 2 (July 2011), available at http://www.urban.org/UploadedPDF/412361-consider-savings.pdf.. . . . 32-33

Center for Health Law and Econ. & Blue Cross Blue Shield of Mass., *Re-Forming Reform* 23, available at http://bluecrossfoundation.org/Policy-and-Research/Reports-By-Topic/National-Health-Reform/~/media//Files/Publications/Policy20%Publications/062110NHRReportFINAL.pdf. 33

Council of Econ. Advisers, *The Impact of Health Insurance Reform on State and Local Governments* 7 (Sept. 15, 2009), available at http://www.whitehouse.gov/assets/documents/documents/cea-statelocal-sept15-final.pdf. . . . 33

Institute of Medicine, *Improving the Quality of Care in Nursing Homes* at 3 (1986).. 21

Kaiser Family Foundation, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options* 17 (Jan. 2012 Update), available at http://www.kff.org/medicaid/upload/8239.pdf.. 31

Keavney Klein & Sonya Schwartz, Nat. Acad. for State Health Pol., *State Efforts to Cover Low-Income Adults Without Children* 3 (Sept. 2008). 22

John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105 (Fall 2000), available at https://www.cms.gov/HealthFinancingReview/Downloads/00fallpg105.pdf.. 31

Letter from Cong. Budget Office to Hon. Olympia Snowe 2 (Jan. 11, 2010), available at http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf). 28-29

Maryland Health Care Reform Coordinating Council, *Final Report and Recommendations* 4-5 (Jan. 1, 2011), available at http://dhmh.maryland.gov/healthreform/pdf/110110FINALREPORT.pdf.. 33

Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* 98-99 (Mar. 2011), available at http://www.macpac.gov/reports.. . 32

N.M. Voices for Children, *The Tax Revenue Benefits of Health Care Reform in New Mexico* (Aug. 2011), available at http://www.nmvoices.org/wp-content/uploads/2011/08/Tax-rev-benefits-of-aca-8-11.pdf. 33

Okla. Policy Inst., *Health Care Reform and the State Budget: Savings Likely to Partly or Fully Offset Modest New Costs* (Oct. 2011), available at http://okpolicy.org/files/StateHealthCareCosts_brief.pdf.. 33

Sara Rosenbaum & Katherine Hayes, *The Misleading Arguments in the States' Medicaid Coercion Brief*, The Health Affairs Blog (Jan. 19, 2012), available at http://healthaffairs.org/blog/2012/01/19/the-misleading-arguments-in-the-states-medicaid-coercion-brief/. 29

Wis. Legislative Fiscal Bureau, *Funding Provided to Wisconsin under the Patient Protection and Affordable Care Act* 1 (Dec. 10, 2010), available at http://www.wccf.org/pdf/PPACA.pdf. 34

INTEREST OF THE *AMICI*[1]

For more than four decades, Congress and the States have chosen to help lower-income people get the health care they need through Medicaid programs. *Amici* are health care provider and consumer organizations that have worked extensively with Medicaid programs. While each *Amicus* has particular interests, they collectively bring to the Court an in-depth understanding of how the Medicaid Act has been amended and implemented over time, at both the national and state levels. The *amici* want to bring accurate information about Medicaid's structure and history to the Court as it considers the constitutionality of the Patient Protection and Affordable Care Act (ACA) Medicaid expansion.

SUMMARY OF ARGUMENT

Beginning in January 2014, the ACA requires participating States to expand their Medicaid programs to include certain non-disabled, non-elderly individuals whose incomes are below 133% of the Federal poverty level ($14,856 for an individual in the contiguous U.S. in 2012). Contrary to Petitioner States' assertions, this expansion does not represent "an extreme and unprecedented abuse of Congress' spending power," nor does it "revolutionize" Medicaid

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[1] Counsel for the parties have filed with the Clerk blanket consents to *amicus* briefs in this case. 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.

or leave States with "no choice but to continue to participate in Medicaid." Pet. Br. at 23, 34, 18.

The Petitioners' coercion claim is not supported by either the history or the structure of the Medicaid Act, as it was originally enacted or as Congress and the States have changed it over time. In exchange for Federal funding, participating States have always been required to provide a minimum package of benefits to certain population groups—with options to do more. Over time, as social conditions and national interests have changed, the mandates and options have changed. The ACA expansion is part and parcel of this structure.

As with previous Medicaid Act amendments, the ACA expansion neither forces States to participate in Medicaid nor forces individuals to enroll in Medicaid. Medicaid is, and always has been, voluntary for both States and individuals. Since its inception, the Medicaid "deal" has always been attractive to States—generally offering States from 50% to 83% Federal funding and sometimes 100% Federal funding. The ACA's generous Federal funding offer—100% initially and 90% thereafter—neatly reflects this Medicaid feature.

Over the years, Congress has used "maintenance of effort" requirements to assure program stability during transition periods, and the Federal agency administering Medicaid has always had the authority to deny all or partial Federal funding to a State that fails to adhere to the statutory minimums. Legally, there is nothing about the ACA Medicaid expansion that departs from past precedent.

Petitioner States say the ACA Medicaid expansion imposes "onerous new obligations." Pet. Br. at 10. Yet, the 26 States before the Court have already opted to expand their Medicaid programs to some population groups with incomes well above 133% of the Federal poverty level, and 18 States—including several of the Petitioner States—had received Federal permission to extend Medicaid eligibility to low-income non-disabled adults—and had done so—well before enactment of the ACA. And while the Petitioners complain about the "damage" that the ACA will cause, multiple studies conclude that State spending will be less with the ACA than without it.

ARGUMENT

As they did before the district court, the Petitioner States ask this Court to invalidate vital parts of a Social Security Act cooperative-federalism program without offering a "judicially manageable standard or coherent theory" for the Court to apply. *Florida ex rel. Bondi v. U.S. Dep't of Health and Human Servs.*, 780 F. Supp. 2d 1256, 1268 (N.D. Fla. 2011); *see* Resp. Br. at 35-37. Moreover, their arguments are based on incorrect and incomplete statements about how the Medicaid program works and how the ACA has amended it. As shown below, Congress has repeatedly amended the terms of Medicaid, with States that failed to implement those changes putting their entire Federal grant at risk, and the ACA in no way locks States into continuing their Medicaid participation.

I. PETITIONER STATES' ATTACK ON MEDICAID IS AN ATTACK ON MEDICAID'S FRAMEWORK AS IT HAS EXISTED OVER THE HISTORY OF THE PROGRAM.

In 1965, pursuant to its Spending Clause authority, Congress added Title XIX to the Social Security Act, thereby establishing Medicaid. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 343-52. Congress invited States to accept significant Federal funding—payment of half or more of total expenditures in a State—in return for providing health insurance 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 occasions—each time anticipating that participating States would remain in the program and spelling out what they needed to do to maintain Federal financial support. Whenever these changes have occurred, including those in the ACA, they have not altered the six major features of the program's framework:

First, Medicaid is a means-tested program that provides coverage to people who generally cannot afford to purchase private health insurance or for whom private insurance is unavailable. The Medicaid Act does not establish a "government run" health system but rather is an insurance program that enables individuals to gain access to private and public health care providers, including doctors, community health clinics, pharmacies, home health care, 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."[2] Eligible individuals are not now, nor have they ever been, required to enroll in Medicaid.

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 going to 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), 1396d(b). Federal funds cover at least 50% of the costs of each State's program administration, *id.* § 1396b(a)(1), and, for some activities and services,

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[2] 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 to payment of a provider claim when and if it was submitted. *E.g. Okla. Ch. of Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1214 (10th Cir. 2007). As Congress made abundantly clear, the clarification was made to "correct any misunderstandings" 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, pt. 1, 649-50 (2009); *see also* 156 Cong. Rec. H1854, H1856 (Mar. 21, 2010) (Statement of Rep. Waxman) (explaining rationale for the clarification). Thus, 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 by employing providers.

100% of the costs, *id.* §§ 1396b(a)(3)(F)(i), 1396b(a)(4), and 1396d(b) (providing full Federal funding for electronic health records development, immigrant status verification systems, and services provided through the Indian Health Service).

Third, State participation in the Medicaid program is voluntary.[3] 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 its plan and the Medicaid Act and regulations. *See* 42 U.S.C. § 1396a(b). While the Federal payments have always come with strings attached, "participation in the Medicaid program is entirely optional," *Harris v. McRae*, 448 U.S. 297, 301 (1980), and an unwilling State can opt out by withdrawing its Medicaid plan, *see* 42 C.F.R. § 430.48(b)(2) (regarding repayment "[i]f the Medicaid program has been terminated by Federal law or by the State"); *see also Doe 1-13 ex rel. Doe, Sr. 1-13 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).[4]

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[3] *See Florida ex rel. Bondi*, 780 F. Supp. 2d at 1268 (N.D. Fla. 2011) (citing declarations from officials in Nevada and South Dakota as evidence States understand they can terminate participation in Medicaid).

[4] Medicaid borrowed its cooperative federalism framework from the 1935 Social Security Act grant-in-aid programs, Old-Age Assistance (Title I), Aid to Dependent Children (Title IV), and Aid to the Blind (Title X). None of these programs compelled a participating State to remain in the program, any more than Medicaid did in 1965 or does now. *See Steward Mach. Co. v. Davis*, 301 U.S. 548, 612 (1937) (Sutherland, J., dissenting) ("An

In addition, if a State does not withdraw from Medicaid but fails to comply with Federal requirements, the Federal Government can impose sanctions, terminate participation, *or* withhold all or part of a State's Medicaid grant. *See* 42 U.S.C. § 1396c (providing Secretary with discretion to withhold all or part of a noncompliant State's payments); 42 C.F.R. § 430.35(d)(1)(i) (allowing Secretary to make payments "for those portions or aspects of the program that are not affected by the noncompliance"); *id*. §§ 430.60-.104 (describing withholding, notice, and appeal procedures when State fails to comply with Federal requirements). *See also*, *e.g.*, 42 U.S.C. § 1396b(m)(5)(B) (authorizing Secretary to deny payments to State for managed care contractors who fail to provide medically necessary

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illustration of what I regard as permissible cooperation is to be found in Title I of the [social security] act now under consideration. [W]e … have simply the familiar case of federal aid upon conditions which the state, without surrendering any of its powers, may accept or not as it chooses."). The *amicus* brief filed by the Center for Constitutional Jurisprudence states that, in 1935, some members of Congress had doubts about whether the Social Security Act would be constitutional. Ctr. for Const. Juris. Br. 16-19. All those doubts that the *amicus* found, when placed in proper context, were about the unemployment tax-and-credit system and social security insurance and were eventually resolved in favor of their constitutionality by *Steward Machine* and *Helvering v. Davis*, 301 U.S. 619 (1937). The Social Security Act's cooperative-federalism conditional grant-in-aid programs were not challenged in those cases. As the Court would later observe in *Oklahoma v. U.S. Civil Service Comm'n*, 330 U.S. 127, 144 (1947), "[t]he offer of benefits to a state by the United States dependent upon cooperation by the state with federal plans, assumedly for the general welfare, is not unusual." *See also* Edward S. Corwin, *National-State Cooperation—Its Present Possibilities*, 8 Am. L. Sch. Rev. 687, 698-99 (1937) (tracing such programs back to 1862), cited in *Oklahoma*, 330 U.S. at 144 n. 20.

services); *id.* § 1396r(h)(3)(C)(i) (authorizing Secretary to deny payments to State for nursing facilities that are deficient); *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1268 (11th Cir. 2011) (rejecting States' argument that refusal to participate in ACA expansion will automatically result in the loss of all Medicaid funding, finding the "Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state"); *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 292 (4th Cir. 2002) (holding that this sort of system does not unconstitutionally coerce States).[5]

Fourth, a hallmark of the Medicaid program is the considerable discretion that States are given to tailor their programs to meet the health needs of their residents and, thus, there is considerable variation in

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[5] The language giving the Secretary discretion not to terminate the State's entire grant is no accident. As originally enacted in 1935, the Social Security Act contained "all or nothing" language that prohibited any payments to a noncompliant program. *See* Social Security Act of 1935, Pub. L. No. 74-271, §§ 4, 404, 1004, 49 Stat. 620, 622, 628-29, 646-47. In 1962, however, Congress provided the Secretary with discretion to withhold partial funding when it established a program for State aid to the aged, blind, or disabled. Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 141(a), 76 Stat. 172, 204. That language was subsequently included in the Medicaid Act. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351. In 1968, Congress went back to the other then-existing grant-in-aid programs and amended them to allow partial payments to noncompliant States, noting that suspension of Federal funds for the entire program "is such a severe penalty that is it virtually impossible to invoke." S. Rep. No. 744, 90th Cong., 1st Sess. 169, *reprinted in* 1967 U.S.C.C.A.N. 3006.

Medicaid programs from State to State. While different and changing obligations have been enacted over time, Congress 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 the amount and mix of services they will cover, provider payments, procedures regarding eligibility and enrollment, and program administration, such as use of managed care arrangements in lieu of traditional fee-for-service payment structures.

Fifth, as with all other Social Security Act grant-in-aid programs, Congress reserved the right to make changes over time in what participating States would need to do to continue to participate. *See* 42 U.S.C. § 1304. By the time Congress enacted Medicaid, it had on several occasions added specific conditions to the state plan requirements for the three original grant-in-aid programs. In 1950, for example, Congress required participating States to accept applications from anyone who wanted to apply and to furnish assistance to all eligible individuals with reasonable promptness. *See* Pub. L. No. 81-734, §§ 301(b), 321(b), 341(d), and 351, 64 Stat. 477, 548, 549-50, 553, and 555-56 (1950). In 1960 and 1962, Congress required programs for old age assistance and for aid to the aged, blind, or disabled to employ reasonable standards. *See* Pub. L. No. 86-778, § 601(b), 74 Stat. 924, 987 (1960); Pub. L. No. 87-543, § 141(a), 76 Stat. 172, 197 (1962). When it made these changes, Congress did not give participating States the option of turning a new requirement down and continuing to participate in the program under prior standards. Instead, the new requirements were placed in the state plan requirements section of each Act (its counterpart to Medicaid's section 1396(a)), such that a

State's failure to implement them could be met with federal compliance actions under that program's counterpart to Medicaid's 42 U.S.C. § 1396c.

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, improving access to costly outpatient prescription drugs, and encouraging community-based alternatives to institutional care.

II. MEDICAID'S FRAMEWORK HAS REMAINED CONSISTENT OVER TIME, WITH CONGRESS ESTABLISHING THE FLOOR OF COVERAGE—ALLOWING STATES TO DO MORE—AND REQUIRING PARTICIPATING STATES TO IMPLEMENT THEIR PROGRAMS AS FEDERAL LAW REQUIRES OR LOSE ALL OR PART OF THEIR FEDERAL MEDICAID FUNDING.

The 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 cooperative partnership designed to improve the health access and status of poor Americans. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (1965) (adding Title XIX, codified as 42 U.S.C. §§ 1396-1396d). Participating

states were required to make medical assistance available to low-income residents who were receiving public cash assistance—Old-Age Assistance, Aid to Families with Dependent Children (AFDC), Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to the Aged, Blind, or Disabled. *See* 42 U.S.C. § 1396a(a)(10)(A)(i). States were given options to make medical assistance available above this eligibility floor to families and people with disabilities whose incomes were too high to qualify for public cash assistance. *See id.* §§ 1396a(a)(10)(A)(ii), 1396a(a)(10)(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.* §§ 1396d(a)(1)-(5). States could choose to 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.* §§ 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 for categorically needy individuals (persons eligible for Medicaid because their characteristics placed them in certain population categories and whose incomes and resources fell below designated thresholds) would consist of a minimum set of treatments and services. *Id.* §§ 1396a(a)(10)(A), 1396d. Similarly, States were required to assure that services would be furnished with "reasonable promptness to all eligible

individuals," *id.* § 1396a(a)(8), and that individuals would receive due process when their claims were denied, *id.* § 1396a(a)(3). Congress also included a "maintenance of effort" provision in the Act that, between 1965 and mid-1969, authorized the Secretary to reduce Federal contributions to a State in rough parity to the amount that a State reduced its own contributions to Medicaid and other publicly funded programs. *See* Pub. L. No. 89-97, § 405, 79 Stat. 286, 420-21 (adding § 1117 to the Social Security Act).

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. A maintenance of effort provision ensured stability as programs were being initiated. Such provisions remain an integral part of the Medicaid program today and have not been changed by the ACA. [6]

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[6] The original Medicaid Act prompted States to broaden the scope of eligibility and services available under their Medicaid plans by allowing Federal officials to withhold Medicaid grants to under-performing States. The original Act read:

> The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards

1967: Congress amended the Medicaid Act to require States to cover certain preventive screening and treatment procedures for Medicaid-eligible children under age 21, known as "early and periodic screening, diagnostic and treatment" (EPSDT) services. *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)). Through EPSDT, the Federal and State partnership evolved to cover well-child examinations; vision, hearing and dental care; vaccines, and services needed to address

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> with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

See Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 350 (enacting § 1903(e), codified as 42 U.S.C. § 1396b(e)). Every state but Arizona had signed on to Medicaid by October 30, 1972, when this provision was repealed, *see* Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 230, 86 Stat. 1329, 1410. The House Ways and Means Committee explained the repeal as follows:

> Your committee has been concerned with the burden of the medicaid program on State finances and has included a provision in the bill which would repeal section 1903(e) from the Act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered.

H.R. Rep. No. 92-231, at 100 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4986, 5086. So even as the legislative process was used to lift the sanction, Congress kept the door open for required expansion to take place later.

children's health problems. Thus, the service floor was raised, and all States now cover EPSDT.[7]

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-administered cooperative-federalism programs. *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381-82 (described below) and § 301, 86 Stat. 1329, 1465-78 (replacing Title XVI of the Social Security Act); *see also* Pub. L. No. 93-233, § 13(A)(3), 87 Stat. 947 (amending 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. Also, all States maintained flexibility to cover people with disabilities whose incomes exceeded the SSI limits.

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[7] Congress has maintained focus on low-income children. For example, EPSDT coverage has been clarified, *see* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2263-64 (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, § 13631, 107 Stat. 312, 636-45 (adding 42 U.S.C. § 1396s).

Concerned that some States might exercise their right to terminate participation in the Medicaid program rather than implement the mandatory expansion, Congress gave States the option to provide Medicaid to only those aged, blind and disabled people who would have been eligible for Medicaid under the State's prior Medicaid plan—with one significant exception. *See* 42 U.S.C. § 1396a(f) (also called § 209(b)). *See* S. Rep. No. 93-553 at 55-57 (1973). Contrary to the Petitioners' characterization of this Congressional action, Pet. Br. at 3-4, Congress did not simply offer States a take-it-if-you-want option; rather, it required States electing the 209(b) option to create programs that would allow aged, blind and disabled individuals to obtain Medicaid income eligibility by deducting their expenses incurred for medical care. In other words, to maintain Medicaid participation, these States could not use a hard eligibility cut-off for the aged, blind and disabled, but would need to extend Medicaid to such individuals of any income level provided that deduction of their medical expenses qualified them for the program.

1981: In 1981, the Federal government revised coverage of long term care services in Medicaid, which were focused on institutional care, to reflect the evolving national interest in allowing individuals to live in their homes and communities. *See* Omnibus Budget Reconciliation Act (OBRA) of 1981, Pub. L. No. 97-35, § 2176, 95 Stat. 357, 812-13 (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 and non-medical services and supports in the community.

Enrollees who needed an institutional level of care could receive these services and supports if the State provided necessary assurances to the Federal government that the coverage would be cost-effective and that enrollees' 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 lower income people. Indeed, State community-based care innovation has flourished under these Federal standards.

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

A. Children and pregnant women

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, § 2361, 98 Stat. 494, 1104 (codified at 42 U.S.C. §§ 1396d(n), 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, § 9501, 100 Stat. 82, 201 (amending 42 U.S.C. § 1396d(n)(1)). A year later, in 1986, 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, § 9401, 100 Stat. 1874, 2050 (codified at 42 U.S.C. §§ 1396a(l), 1396a(a)(10)(A)(ii)). As part of this new option, Congress sought to protect low-income families whose eligibility was tied to the AFDC program and, thus, included a maintenance of effort provision prohibiting States from taking up the new Medicaid option if they were reducing AFDC payment levels below their 1986 standards. *See id.* § 9401(b) (adding 42 U.S.C. § 1396a(l)(4)(A)); *see* H.R. Rep. No. 99-727, at 99-100, *reprinted in* 1986 U.S.C.C.A.N. 3689-90; *see also* Pub. L. No. 100-203, § 4101(e)(4), 101 Stat. 1330-140, 1330-142 (1987) (amending 42 U.S.C. § 1396a(l)(4)(A)).

In 1988, Congress began to transform these options 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.

No. 100-360, § 302, 102 Stat. 683, 750 (codified at 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(2)(A)(iii)); OBRA of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258 (amending 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396a(a)(A)(10)(A)(ii), 1396a(l)); OBRA of 1990, Pub. L. No. 101-508, § 4601(a)(1), 104 Stat. 1388, 1388-166. During this time, Congress allowed States, as it had during previous years, to extend benefits to needy children and pregnant women with incomes above the minimum coverage floors. *Id*.

Congress enacted all of these mandatory requirements as amendments to 42 U.S.C. § 1396a—thus exposing a State that refused to implement them to the risk of losing all or part of its Medicaid grant under § 1396c. In fact, on one occasion, to assure programmatic stability, Congress included a maintenance of effort provision that temporarily conditioned the entire Medicaid grant on the States' maintenance of AFDC payment levels at the 1988 levels. *See* 42 U.S.C. § 1396a(c)(1) (providing that "the Secretary shall not approve any State plan for medical assistance if the State has in effect [AFDC] payment levels that are less than the payment levels in effect under such plan on May 1, 1988"), repealed by Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 114(d), 110 Stat. 2105, 2180.

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 low-income children and pregnant women, such as community health clinics and hospitals. *See* 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]

B. Aged, blind and disabled individuals

During this same time period, 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 cost sharing. The 1965 Medicaid Act authorized States to make Medicare Part A premium payments and Part B cost-sharing payments for Medicaid recipients, as well as Part B premium payments on behalf of low-income recipients of cash benefits. *See* Pub. L. No. 89-97, §§ 121, 122, 79 Stat. 286, 353 (codifying then 42 U.S.C. § 1396a(a)(15)). In 1986, Congress created a new

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[8] *Cf.* 42 U.S.C. § 1396r-1(e) (optional presumptive eligibility for non-disabled, non-elderly adults, added by ACA § 2001(a)(4) (effective 2014)).

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 Federal poverty line. *See* OBRA of 1986, Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053 (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 the poverty line. *See* MCCA, Pub. L. No. 100-360, § 301, 102 Stat. 683, 748 (amending 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(p)).

In 1990, 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, Pub. L. No. 101-508, § 4501, 104 Stat. 1388, 1388-164 (amending 42 U.S.C. §§ 1396b(a)(10)(E)(ii), 1396d(p)(2)). Finally, in § 4732 of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, Congress created the "Qualified Individual" program, through which most States provide cost-sharing assistance to Medicare beneficiaries with incomes up to 135% of the poverty level. 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. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 134, 96 Stat. 324, 375 (adding 42 U.S.C. § 1396a(e)(3)). All of these changes were enacted as amendments to 42 U.S.C. § 1396a—and so all of them triggered complete or partial defunding, under 42 U.S.C. § 1396c, of a State that refused to implement one of them or, in the case

of the TEFRA option, purported to implement but failed to do so.

Also during this time period, the Medicaid Act was amended to address broad national concerns for the aged, blind, and disabled. In response to a series of studies identifying "grossly inadequate care and abuse of residents" in nursing homes, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* at 3 (1986), Congress added provisions commonly known as the Nursing Home Reform Act. *See* 42 U.S.C. § 1396r (added by OBRA of 1987, Pub. L. No. 100-203, §§ 4211-13, 101 Stat. 1330, 1330-182-1330-219). Among other things, these provisions require Medicaid-funded nursing facilities to provide services in accordance with individualized written plans of care, use only properly trained nursing aides, and engage in preadmission screening to ensure that individuals with mental illness or intellectual disabilities are not improperly placed in nursing facilities. *Id.*

1993–2009: The 1993 to 2009 time frame saw Congress further enhancing States' options for operating their Medicaid programs, for example providing States significant leeway to use Federal funds to provide Medicaid services through managed care delivery systems, such as HMOs. *See, e.g.,* 42 U.S.C. § 1396u-2 (added by Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4701(a), 111 Stat. 251, 489-92) (authorizing state plan amendments to require mandatory enrollment in managed care entities).

In another significant change, Congress required participating States to be involved in a broad effort to improve access to outpatient prescription drugs. As of January 2006, individuals who qualify for both

Medicare and Medicaid are automatically enrolled in Medicare Part D. *See* 42 U.S.C. §§ 1395w-101-134, 1396u-5 (added by Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2006, 2071-2131). As a condition of its State plan and receipt of any Federal funding, a State must screen individuals for dual eligibility and offer them enrollment in the State plan. *See* 42 U.S.C. § 1396u-5(a)(3). States must also reimburse the Federal government for prescription drug costs based on State-specific enrollment in Part D of people eligible for both Medicare and Medicaid. *See id.* § 1396u-5(c).

There is also ample precedent from this time period for Medicaid coverage of low-income non-disabled and non-elderly adults (the population group assisted by the ACA Medicaid expansion). 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 non-disabled and non-elderly adults whose incomes fall below a State-set percentage of the Federal poverty level. By 2008, 18 States had received Federal permission to extend coverage to these adults using Federal Medicaid funds, including Petitioners 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); *cf.* James F. Blumstein & Frank L. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 Vand. L. Rev. 125, 270 (2000) (suggesting Tennessee's § 1315 program as a "model of broader health care

reform—achieving broader access goals by recapturing and reallocating Medicaid savings for improved access for uninsured and uninsurable (but not Medicaid eligible) beneficiaries").

In the final major Federal legislation pre-dating the ACA, Congress enacted the American Recovery and Reinvestment Act (ARRA), which included provisions to strengthen use of health information technology. As part of this effort, ARRA made Medicaid funds available to States—at a 100% Federal match—for expenditures to help Medicaid-participating providers establish electronic health records systems. *See* 42 U.S.C. §§ 1396b(a)(3)(F), 1396b(t). ARRA also included a maintenance of effort provision that provided States enhanced Federal matching rates to maintain their Medicaid eligibility levels during the economic recession in 2010 and part of 2011. To receive the enhancement, States could not shift Medicaid costs onto cities or counties, delay payments to providers, deposit the enhanced payments into a rainy day fund, or reduce eligibility standards below those in effect on July 1, 2008. *See* ARRA, Pub. L. No. 111-5, § 5001(f), 123 Stat. 115, 499-500 (2009).

III. THE AFFORDABLE CARE ACT DOES NOT CHANGE MEDICAID'S FRAMEWORK: MEDICAID REMAINS VOLUNTARY FOR STATES AND INDIVIDUALS, AND FEDERAL AUTHORITY TO WITHHOLD ALL OR PART OF A NONCOMPLYING STATE'S GRANT HAS NOT CHANGED.

In 2010, the United States Congress, including a super-majority of the Senate, enacted the ACA. In the context of covering America's uninsured, the ACA

Medicaid expansion was neither substantial nor unforeseeable. The 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 Medicaid coverage of Medicare cost sharing amounts for 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 non-disabled, non-elderly adults with family incomes below 133% of the poverty level. States have the option to implement the expansion early (and some states are doing so). As is typical for the Medicaid program, States retain options to provide additional coverage beyond the Federal floor. As has previously been the case, the Federal Secretary maintains discretion to withhold all or partial funding to a State that is failing to comply with the Federal mandates.[9]

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[9] Petitioners' theory that Federal discretion is not available with respect to the ACA's Medicaid expansion, Pet. Br. at 35-36 n.15,

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 the expansion group. *See* 42 U.S.C. § 1396d(y)(1). The Federal government will also pay

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rests on a misunderstanding of what the Court of Appeals actually held, what 42 U.S.C. § 1396c says, and what the Federal Government has actually argued. The Court of Appeals did not say that the Act "leaves the Secretary with discretion to allow States to continue participating in Medicaid without abiding by the ACA's new terms." It said, correctly, that "the Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state." 648 F.3d at 1268. How large a withheld "portion" might need to be to ensure State compliance with this particular Medicaid mandate is, per the text of § 1396c, initially a matter of the Secretary's "discretion," perhaps "limit[ing payments] to categories under or parts of the State plan not affected by such failure," perhaps focused on the Federal match for State administrative costs. *See West Virginia*, 289 F.3d at 293, n.8 (4th Cir. 2002). In *West Virginia*, the Federal Government described a range of possible sanctions, and nowhere in its briefing here or below has it asserted that this range of possible sanctions, up to and including complete defunding, would not be available to deal with a State attempt to stay in Medicaid but refuse to comply with the program's statutory terms. *See also* Resp. Br. at 4, 40-41. So far as *amici* are aware, the *West Virginia* case is the only reported case (other than the Eleventh Circuit decision under review) in which a court has accepted that the coercion doctrine applies to Medicaid, considered a State's contention that "the federal government would withhold *all* of [a State's] federal Medicaid funds unless [the State] implemented [a newly mandatory part of the Medicaid] program," *id.* at 291, rejected that contention, and determined that Medicaid is or is not unconstitutionally coercive.

90% of the funding necessary for State development of new Medicaid eligibility systems through 2015. *See* 76 Fed. Reg. 21,950 (Apr. 19, 2011).[10]

Additionally, as it has on previous occasions, Congress included a "maintenance of effort" provision to discourage States from dropping coverage between now and 2014. Like the 1988 maintenance provisions, the ACA provision forbids a State from reducing eligibility standards below standards in effect on a certain date (the ACA's enactment), on condition of not receiving Medicaid payments. *See* ACA § 2001(b) (codified at 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)). As with previous maintenance provisions, the ACA requirement is temporary and will expire on January 1, 2014 (2019 for children), after which States will be free to reduce optional Medicaid eligibility. The ACA also includes a feature that allows a State to reduce Medicaid eligibility to certain non-disabled adults if it certifies to the Secretary that it has a "budget crisis" or projects a budget deficit. *Id.* (*Amici* are aware of only

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[10] Petitioners complain that the ACA's Medicaid provisions will force them to spend more money, but they have not argued that the provisions are unconstitutional unfunded mandates, and such an argument would not be well taken. Pet. Br. at 16-17. The statute that makes Members of Congress politically accountable in this situation is the Unfunded Mandates Reform Act of 1995, Pub. L. No. 104-4, 109 Stat. 48. Senator Corker raised a point of order under this Act against the ACA's Medicaid provisions. *See* 155 Cong. Rec. S13803-04 (daily ed. Dec. 23, 2009). In response, Senator Baucus referred to the ACA's initial 100% and ultimate 90% federal funding for the extension of Medicaid coverage and said that this is a very fair deal for States. The Senate rejected the point of order by a vote of 55-44. *See* 155 Cong. Rec. S13831 (daily ed. Dec. 23, 2009).

three States, Hawaii, Maine, and Wisconsin, that have sought this relief.)

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 for dynamic, innovative programs for covering long-term care and home care for older people and people with disabilities. *E.g.,* ACA § 2401 (Community First Choice), ACA § 2403 (Money Follows the Person Rebalancing). The ACA also expands an existing system for renewing Medicaid waivers that serve people who get both Medicaid and Medicare and establishes a Federal office for coordinating coverage for people who get benefits under both programs. ACA §§ 2601 and 2602.

Voluntary participation by States and by individuals: Medicaid enrollment remains voluntary for States and for individuals. Congress left Medicaid enrollment voluntary for individuals precisely because the program is voluntary for States: Congress could not require low-income people to enroll, since no State needs to participate in Medicaid. As has been the case over the entire history of the Medicaid program, the consequences of State withdrawal would be harsh for a State's low-income residents and people with disabilities, but the reality is that the entire system remains voluntary for the poorest U.S. residents.

According to the Petitioners, "State participation in Medicaid is not a matter open to choice," because:

Minimum essential coverage requirements reach all but exempt persons; Medicaid is an identified form of minimal essential coverage; and individuals with incomes below 100% of poverty are not eligible for advance premium tax credits through State Exchanges. Thus, according to Petitioners, Medicaid becomes the only option for fulfilling the minimum coverage requirement, and this "lack of a contingency plan" must mean that Congress "transformed" Medicaid to "a program to provide a minimum level of coverage to every needy person." Pet. Br. at 34-35. There are a number of problems with this construct. First, it is not true that Medicaid is the only source of coverage for low-income people; many of them will satisfy the mandate with Medicare, care through the Veterans' Administration, other types of government-financed care, or employer-provided insurance. *See* 26 U.S.C. § 5000A(f)(1) (listing seven government programs as satisfying "minimum essential coverage"). Second, the vast majority of individuals who will be eligible for Medicaid in 2014 and thereafter will face no penalties in the absence of Medicaid for failing to obtain minimum essential coverage, either because their incomes are below the federal income tax filing threshold, because the required contribution for an available policy will exceed eight percent of their incomes,[11] or because they can obtain a hardship

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[11] *See* Resp. Br. at 49 & n. 22 (correctly suggesting that a newly eligible individual with income at 138% of the poverty level will never be able to afford the least expensive, bronze policy). Using 2010 figures, 8% of that person's yearly income would be $1195, *id.*, but "[a] Bronze plan in 2016 will cost an individual between $4,500 and $5,000 a year." 156 Cong. Rec. S2069, 2081 (daily ed. Mar. 25, 2010) (Statement of Sen. Durbin) (citing Letter from

exception. *See* 26 U.S.C. §§ 5000A(e)(1), (e)(2), (e)(5) (describing these as exemptions from minimum essential coverage requirements).

Third, Petitioners' argument does not change the reality that Medicaid is—as it has always been—voluntary for States and low-income individuals. Whatever happens to poor people in a State that opts to leave Medicaid rather than expand it, "this is the headache that Congress created for itself by excluding this population from the Act's premium tax credit and Exchange provisions." Sara Rosenbaum & Katherine Hayes, *The Misleading Arguments in the States' Medicaid Coercion Brief*, The Health Affairs Blog (Jan. 19, 2012).[12] As Professors Rosenbaum and Hayes conclude,

> One could argue that Congress should not have made so many operational and policy assumptions about the deal it was offering…. One might take the position … that Congress should have anticipated an exodus by some states and created a fallback system of … coverage … for poor people living in states that choose not to participate in Medicaid. This might have been a viable policy choice, not to mention the moral and ethical thing as a means

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Cong. Budget Office to Hon. Olympia Snowe 2 (Jan. 11, 2010), available at http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf).

[12] http://healthaffairs.org/blog/2012/01/19/the-misleading-arguments-in-the-states-medicaid-coercion-brief/.

> of assuring that most Americans truly will have access to affordable insurance coverage. Congress did not make that choice however….

Id.

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. To participate, States must adhere to minimum federal 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.

IV. MEDICAID SPENDING IS WHAT IT IS BECAUSE STATES HAVE AGGRESSIVELY TAKEN UP FEDERAL OPTIONS, AND STATES' SAVINGS UNDER THE AFFORDABLE CARE ACT WILL EXCEED THEIR COSTS.

The Petitioner States argue that the sheer size of the Medicaid program has grown significantly over time. This growth is due in large part to options the States themselves chose.

At the time of the program's start, States made unexpectedly great use of Medicaid options—choosing to expand their programs beyond the minimum coverage floors established in the Medicaid Act to

include groups and services that Congress did not require them to cover. See John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105, 106 (Fall 2000).[13] This State uptake of options has become a consistent hallmark of the program over time. In fiscal year 2007, 60.4% of all Medicaid spending was attributable to States' optional expenditures on mandatory populations and expenditures on optional populations. *See* Kaiser Family Foundation, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options* 17 (Jan. 2012 Update).[14] As is typical for Medicaid, there is variation among the States. For example, 76.5% of expenditures in Petitioner North Dakota are attributable to this optional spending; 74.7%, in Ohio; 74%, in Wisconsin; 69.4%, in Iowa; 69.2%, in Maine; 67.4%, in Nebraska; 61.5%, in Indiana; 53%, in Florida. *Id*.

Eighteen of the Petitioner States–all but Alabama, Colorado, Idaho, Nevada, North Dakota, South 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 id.* at 14. In addition, all 26 of the Petitioner States' Medicaid programs cover, as a matter of State option, at least some elderly people and/or people with disabilities with incomes up to about 224% of Federal

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[13] Available at https://www.cms.gov/HealthCareFinancingReview/Downloads/00fallpg105.pdf.

[14] Available at http://www.kff.org/medicaid/upload/8239.pdf.

poverty level.[15] The Petitioner State officials should not be heard to complain now that the Medicaid program is too large—for its size is due, in large part, to choices the States themselves have made to expand coverage through Federal funding options that Congress made available to them over the last 46 years as participants in the Medicaid program.

Moreover, independent analyses have concluded that total State savings will exceed new costs under the ACA. *See* Resp. Br. at 11, 26-29. Among other things, savings will be attributable to increased Federal matching percentages offered under the ACA, reductions in Medicaid enrollment of people who become covered under employer-sponsored plans, and reductions in State funding of safety-net providers, such as community clinics and public hospitals, due to the expansion in insurance coverage. The ACA will roughly halve State spending on uncompensated care for uninsured people, collectively saving $26 billion to $52 billion, and reduce State spending on individuals with mental illness, collectively saving between $11 billion and $22 billion from 2014-2019. *See* Matthew

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[15] Table 11 of the Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* 98-99 (Mar. 2011), available at http://www.macpac.gov/reports, shows that 23 of the 26 States cover individuals needing a nursing home level of care with incomes at 224% of poverty. Of the 3 remaining States, Alaska and Nebraska cover working individuals with disabilities with family incomes up to 250% of poverty, Alaska Stat. § 47.07.020(b)(12), Neb. Rev. Stat. § 68-915(8), while North Dakota covers workers with disabilities with family incomes up to 225% of poverty, North Dakota Century Code § 50-24.1-02.7. Alaska has recently restored the 300%-of-SSI long-term-care eligibility system used in the other 23 Petitioner States, *see* Alaska Stat. § 47.07.020(b)(6).

Buettgens, Stan Dorn, & Caitlin Carroll, The Robert Wood Johnson Found. and Urban Inst., *Consider Savings as Well as Costs* 2 (July 2011).[16]

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[16] Available at http://www.urban.org/UploadedPDF/412361-consider-savings.pdf. In 2009, the Council of Economic Advisers estimated costs and savings in 16 states, including Florida, Idaho, Indiana, Iowa, Maine, Michigan, Nebraska, Pennsylvania, and Wyoming, and concluded that "the saving to state governments from health insurance reform is substantial,… with the savings more than offsetting the additional Medicaid costs in every one of the sixteen states." Council of Econ. Advisers, *The Impact of Health Insurance Reform on State and Local Governments* 7 (Sept. 15, 2009), available at http://www.whitehouse.gov/assets/documents/documents/cea-statelocal-sept15-final.pdf. Only 12 of the 26 Petitioner States submitted evidence to the district court on the cost of the ACA Medicaid expansion, and only 3 of the States attempted to rebut the suggestion by the Council that there would be net overall savings. *Cf.* Maryland Health Care Reform Coordinating Council, *Final Report and Recommendations* 4-5 (Jan. 1, 2011) (projecting "substantial savings to Maryland's budget over the next ten years"), available at http://dhmh.maryland.gov/healthreform/pdf/110110FINALREPORT.pdf; Center for Health Law and Econ. & Blue Cross Blue Shield of Massachusetts, *Re-Forming Reform* 23 (estimating $300 million/year savings in Medicaid alone between 2014-2019), available at http://bluecrossfoundation.org/Policy-and-Research/Reports-By-Topic/National-Health-Reform/~/media//Files/Publications/Policy%20Publications/062110NHRReportFINAL.pdf; N.M. Voices for Children, *The Tax Revenue Benefits of Health Care Reform in New Mexico* at 2-3, 5-6 (Aug. 2011) (projecting that cost of Medicaid expansion 2014-2020 will be more than offset by anticipated state revenues), available at http://www.nmvoices.org/wp-content/uploads/2011/08/Tax-rev-benefits-of-aca-8-11.pdf; Okla. Policy Inst., *Health Care Reform and the State Budget: Savings Likely to Partly or Fully Offset Modest New Costs* (Oct. 2011) (citing RWJF estimate of net $60 million cost to $367 million savings over 2014-2019 and refuting cost projections of Cato Institute and Oklahoma Council of Public Affairs), available at http://okpolicy.org/files/StateHealthCareCost

CONCLUSION

The Court should affirm the Eleventh Circuit's decision upholding the constitutionality of the ACA Medicaid expansion, thereby ensuring that Medicaid can play its proper role in helping lower-income people get the health care they need in States that choose to participate in the program.

Dated: February 15, 2012

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s_brief.pdf; Wis. Legislative Fiscal Bureau, *Funding Provided to Wisconsin under the Patient Protection and Affordable Care Act* 1 (Dec. 10, 2010) (estimating approximately $364.6 million in savings from 2014-2016 from the Medicaid expansion), available at http://www.wccf.org/pdf/PPACA.pdf.