Nos. 19-840, 19-1019

In the Supreme Court of the United States

CALIFORNIA, ET AL., *Petitioners*,
v.
TEXAS, ET AL., *Respondents.*

TEXAS, ET AL., *Petitioners*,
v.
CALIFORNIA, ET AL., *Respondents.*

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF NATIONAL HEALTH LAW PROGRAM, AMERICAN MEDICAL STUDENT ASSOCIATION, AMERICAN PHYSICAL THERAPY ASSOCIATION, ASIAN AND PACIFIC ISLANDER HEALTH FORUM, ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS (AAPCHO), CALIFORNIA PAN-ETHNIC HEALTH NETWORK, LAW FOUNDATION OF SILICON VALLEY, NATIONAL LGBTQ TASK FORCE, NATIONAL WOMEN'S HEALTH NETWORK, REPRODUCTIVE HEALTH ACCESS PROJECT, AND WE TESTIFY, AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS SUGGESTING REVERSAL

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INTEREST OF THE *AMICI*[1]

For more than five 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 consumer and provider organizations that work with Medicaid programs. These organizations have direct knowledge of Medicaid's history of promoting health equity and improving the lives of low-income people—particularly women, children, LGBTQ individuals, and people of color. 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, including the significant improvements made to Medicaid in the Patient Protection and Affordable Care Act (ACA). *Amici* want to bring information about Medicaid's structure and history to the Court as it considers the viability of the ACA after Congress set the amount of the ACA's tax penalty to zero.

SUMMARY OF ARGUMENT

The Medicaid Act provides federal funding to participating states, enabling them to make payments to hospitals, long-term care facilities, and community-based providers who render necessary care to the limited-income people who qualify for coverage. If the

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[1] 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. All parties have consented to the filing of this brief.

Court concludes that what remains of the minimum-coverage provision in Title I of the ACA is unconstitutional, then it should sever the ACA's Medicaid amendments and allow them to remain in effect.

The premise of the Medicaid severability arguments *Amici* present here is that the Court will have determined that in *California v. Texas*, Nos. 19-840 and 19-1019, at least some of the plaintiffs (Messrs. Nantz and Hurley and various States) have standing to attack what remains of the individual mandate as unconstitutional; that what remains of the individual mandate is, in fact, unconstitutional, as opposed to being simply unenforceable and carrying no legal consequences; and that it is appropriate as a matter of severability doctrine to consider whether other provisions of the ACA cannot be severed from what remains of the individual mandate. Each element of that premise is deeply contestable. Nevertheless, if the Court does subject the remainder of the ACA to a severability inquiry based on Congress's intent in 2010, the conclusions it should reach about Medicaid are clear.

The Medicaid amendments do not depend in any way on the minimum-coverage provision. They are set forth in an entirely separate part of the ACA, Title II. Over Medicaid's 55-year history, Congress has regularly amended the Medicaid Act, building upon the Act as it then stood and tacking the changes onto multi-issue legislation, such as health, appropriations, or budget bills. Congress followed that same pattern when it included the Medicaid amendments in the

ACA. Because the ACA's Medicaid amendments are functionally independent from the ACA's minimum-coverage provision, and because Congress's plan to increase quality health care coverage for low-income people is well-served by the Medicaid provisions it enacted, those provisions should remain intact no matter what the Court does with the minimum-coverage provision.

ARGUMENT

The coverage Medicaid provides for low-income people is essential. Medicaid was an independent program at the time of its enactment, and its framework and the processes for its amendment have remained consistent over time. The ACA made changes to the Medicaid Act that build upon the program as it has evolved since 1965 and that are entirely independent of the individual mandate. Therefore, the ACA's Medicaid provisions are completely severable from the individual mandate.

I. MEDICAID PROVIDES ESSENTIAL HEALTH COVERAGE TO LOW-INCOME PEOPLE.

- Kimberly W. is a 47-year-old wife and mother of two. She has rheumatoid arthritis, which makes it painful to stand. Despite this, she has worked all her life in hotels, fast food restaurants, gas stations, and, most recently, a rehabilitation center. These jobs did not offer health coverage. As a result of the ACA's Medicaid expansion to non-disabled, non-elderly adults, she was able to

enroll in Kentucky Medicaid and get treatment for her conditions.

- Amber J. is a 23-year-old who spent much of her youth in foster care. She has graduated from college, works at a nonprofit organization in Florida, and plans to obtain a Master's Degree. She has congenital heart disease and Klippel Feil syndrome, which causes spinal fusion. She has access to the services she needs to treat these conditions because of the ACA's Medicaid amendments, which extended Medicaid coverage to former foster youth up to age 26.

- Maria Y. is a 53-year-old Michigan resident. She taught kindergarten full-time until her health problems made it impossible. Now she works as a substitute teacher. She has many health problems, including arterial spasms and post-concussion syndrome. She is in need of specialty care and prescriptions to address her conditions. This care is covered through Michigan's Medicaid expansion to non-disabled, non-elderly adults.

These people are just three of the millions covered by Medicaid, thanks to changes included in Title II of the ACA. Over its 55- year history, Medicaid has made it possible for hundreds of millions of low-income people living in the United States to receive health care. The ACA has made improvements to the program and broadened Medicaid's scope to build on its achievements and continue the work of providing quality health care services to low-income people.

Enacted in 1965, the Medicaid Act was established as a cooperative venture between the federal and state governments to provide health coverage for specific groups of low-income people. Congress's "very clear ... intent [was] that the medical and remedial care and services made available to recipients . . . be of high quality and in nowise inferior to that enjoyed by the rest of the population." Rand E. Rosenblatt et al., *Law and the American Health Care System* 416 (1997) (quoting U.S. Dep't of Health, Educ., & Welfare, Handbook of Public Assistance Administration § D-5144 (1966)).

While states are not required to participate in Medicaid, all do—as do the District of Columbia and all U.S. territories. Cong. Research Serv., *Medicaid Primer*, Congress.gov (Nov. 21, 2018), https://crsreports.congress.gov/product/pdf/IF/IF10322. Today, nearly 65 million Americans are covered by Medicaid for their health care at some point during the year. Ctrs. for Medicare & Medicaid Servs., *Medicaid Facts and Figures* (Jan. 30, 2020), https://www.cms.gov/newsroom/fact-sheets/medicaid-facts-and-figures.

Medicaid covers more than 36 million children. Ctrs. for Medicare & Medicaid Servs., *Federal Fiscal Year (FFY) 2018 Statistical Enrollment Data System (SEDS) Reporting* 3 (May 1, 2019), https://www.medicaid.gov/sites/default/files/2019-12/fy-2018-childrens-enrollment-report.pdf. More than 16 million U.S. women between the ages of 19 and 64 rely upon Medicaid for critical health care services, including breast and cervical cancer screening and treatment, testing and treatment for sexually

transmitted diseases, family planning services, and pregnancy-related care. Kaiser Family Found., *Women's Health Insurance Coverage* (Jan. 24, 2020), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/.

Medicaid covers approximately 11 million nonelderly individuals, including 6.1 million children, with severe physical and/or mental disabilities such as cerebral palsy, Down Syndrome, and autism. MaryBeth Musumeci & Priya Chidambaram, Kaiser Fam. Found., *Medicaid's Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending* (June 12, 2019), https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/; Kaiser Fam. Found., *Medicaid Enrollees by Enrollment Group*, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/. Medicaid provides either full-scope Medicaid benefits or pays Medicare cost sharing for more than 10 million low-income Medicare beneficiaries. MaryBeth Musumeci, Kaiser Fam. Found., *Medicaid's Role for Medicare Beneficiaries* (Feb. 16, 2017), https://www.kff.org/medicaid/issue-brief/medicaids-role-for-medicare-beneficiaries/.

Medicaid coverage is particularly important for people of color, who, due to the ongoing impacts of structural racism and inequality in the U.S., have higher rates of chronic health conditions that require ongoing screening and services, such as diabetes. U.S. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *National Diabetes Statistics*

Report 2020, at 5, 17 (2020), https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Medicaid covers more than 34 million non-elderly Black, Hispanic, Asian/Hawaiian/Pacific Islander, and Native Americans. Kaiser Fam. Found., *Distribution of Non-Elderly with Medicaid by Race/Ethnicity 2018*, https://www.kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4/?dataView=1. Thirty-four percent of African Americans, 32 percent of Hispanics, and 36 percent of Native Americans/Alaska Natives receive insurance coverage through Medicaid. Kaiser Fam. Found., *Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity*, https://www.kff.org/medicaid/state-indicator/rate-by-raceethnicity-3/.

Lesbian, gay, bisexual, and transgender (LGBT) people face significant challenges accessing health services, due in part to discrimination and stigma. Many LGBT individuals also have low incomes and lack access to health insurance. Jennifer Kates et al., Kaiser Fam. Found., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.* (May 2, 2018), https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/view/print/. The ACA significantly increased access to Medicaid coverage for this population, from 7 to 15 percent – more than half a million more lesbian, gay, and bisexual individuals in 2016 than 2013. Lindsey Dawson et al., Kaiser Fam. Found., *The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation* (Jan. 18, 2018), https://www.kff.org/disparities-policy/issue-brief/the-

affordable-care-act-and-insurance-coverage-changes-by-sexual-orientation/.

Medicaid is also crucial to rural populations. Compared to people in urban areas, people living in rural areas are more likely to have low income and less likely to have access to private health insurance. Not surprisingly, working adults in rural communities are more likely to be covered by Medicaid. Julia Foutz et al., Kaiser Fam. Found., *The Role of Medicaid in Rural America* (Apr. 25, 2017), https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/. More children in rural areas are enrolled in Medicaid or the much smaller Children's Health Insurance Program (CHIP) than urban children; 45 percent compared to 38 percent in a recent survey. Ctr. on Budget & Pol'y Priorities, *Medicaid Works for People in Rural Communities* (Jan. 19, 2018), https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities.

Medicaid does not merely provide coverage—it enables people to have meaningful access to quality care. Ninety-five percent of children covered by Medicaid or CHIP have an established source of care, as do 90 percent of non-elderly adult beneficiaries, comparable to rates in private insurance. Julia Paradise, Kaiser Fam. Found., *Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid* (Mar. 23, 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/. Child and adult Medicaid beneficiaries are as likely to receive

primary and specialty care as their counterparts in private insurance. *Id.*

Medicaid coverage contributes to significant reductions in infant and child mortality, reduces disability, improves long-term educational attainment, and leads to lower rates of emergency department visits and late-life hospitalization. *Id.* A recent study showed that Medicaid beneficiaries received preventive care, such as blood pressure checks, colon cancer screenings, mammograms, and flu shots, at rates comparable to those with private insurance. Munira Z. Gunja et al., Commonwealth Fund, *How Medicaid Enrollees Fare Compared with Privately Insured and Uninsured Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey 2016* (Apr. 27, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/apr/how-medicaid-enrollees-fare-compared-privately-insured-and. Access to these preventive services is a key factor in reducing morbidity and mortality among Medicaid beneficiaries.

II. MEDICAID WAS AN INDEPENDENT PROGRAM AT THE TIME OF ENACTMENT, AND ITS FRAMEWORK AND THE PROCESSES FOR AMENDING IT HAVE REMAINED CONSISTENT OVER TIME.

In 1965, the Social Security Act addressed issues ranging from housing to nutrition and cash assistance. Congress added the Medicaid Act, Title XIX to the Social Security Act, to furnish medical assistance to people whose limited incomes did not allow them to afford necessary care. *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). In exchange for generous federal funding, states agreed to abide by the requirements of the program set forth in statute, regulation, and policy.

In the beginning, 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. 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. *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 services, and physicians' services. *Id.* §§ 1396d(a)(1)-(5). States could choose to receive federal funding for a number of other services, including outpatient prescription drugs, preventive screening services for children, home health, and dental care. *Id.* §§ 1396d(a)(6)-(15).

As with 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 in Medicaid. *See* 42 U.S.C. § 1304. Congress has exercised that right on numerous occasions, using a variety of legislative vehicles to

adapt the Medicaid program to changing population needs and developments in the delivery of health care. Sometimes Congress has amended Medicaid using dedicated health legislation; other times it has included Medicaid amendments in multi-issue legislation such as appropriations and budget bills. To illustrate:

Coverage for low-income people who do not receive public cash assistance: 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 sometimes contained in dedicated health legislation and other times in budget bills, Congress established a national floor of health coverage for low-income Americans accompanied by options for states to do more.

For example, as noted, the Medicaid Act originally required participating states to extend Medicaid only to children and pregnant women receiving AFDC cash assistance. States were given the option to extend coverage to children with AFDC-level income but living in families that did not qualify for AFDC, 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. Deficit Reduction Act of 1984 (DRA), Pub. L. No. 96-369, § 2361, 98 Stat. 494, 1104 (codified at 42 U.S.C. §§ 1396d(n), 1396a(a)(10)(A)(i)(III)). Thereafter, Congress transformed Medicaid through phased-in coverage tied to the federal poverty level (FPL), rather than the AFDC program. Coverage ultimately reached all children, birth to age 5, and

pregnant women with incomes at or below 133% of the FPL and, in the case of children aged 5-18, with incomes under 100% of the FPL. 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)); Omnibus Budget and Reconciliation Act (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)(10)(A)(ii), 1396a(l)); OBRA of 1990, Pub. L. No. 101-508, § 4601(a)(1), 104 Stat. 1388, 1388-166.

Similarly, in 1984 Congress required states to provide Medicaid to children who receive foster care or for whom an adoption assistance agreement is in place. DRA, § 2361, 98 Stat. at 1104 (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(I)). Then, in 1999, Congress gave states the option to extend eligibility to children who are in foster care when they turn 18. The state could provide coverage to these children until age 19, 20, or 21, at the state's option. Foster Care Independence Act of 1999, Pub. L. No. 106-169, § 121, 113 Stat. 1822, 1829 (adding 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII)).

Over these years, Congress also addressed eligibility for low-income seniors and people with disabilities. For example, historically, though eligible for Medicare, these groups often 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. Pub. L. No. 89-97, §§ 121, 122, 79 Stat. 286, 353 (codifying then 42 U.S.C. § 1396a(a)(15)). In and

after 1986, Congress created Medicaid provisions extending Medicaid to additional, low-income Medicare enrollees. *See*, *e.g*, OBRA of 1986, Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053 (adding 42 U.S.C. §§ 1396d(p), 1396a(a)(10)(E), allowing states to receive federal payments toward coverage of Medicare cost-sharing for people with incomes below a state-specified threshold or below the FPL); MCCA, Pub. L. No. 100-360, § 301, 102 Stat. at 748 (amending 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(p), requiring states to phase in coverage of Medicare premiums and cost-sharing for all persons with incomes below the FPL); OBRA of 1990, § 4501, 104 Stat. at 1388-164 (amending 42 U.S.C. §§ 1396b(a)(10)(E)(ii), 1396d(p)(2), requiring states to phase in Medicare cost-sharing for people with family incomes up to 120% of the FPL); Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4732, 111 Stat. 251, 520 (creating "Qualified Individual" program, through which most states provide cost-sharing assistance to Medicare beneficiaries with incomes up to 135% of the FPL).

Streamlining the eligibility process: To facilitate Medicaid enrollment of children and pregnant women, the 1990 Congress required states to allow processing of Medicaid applications not only at public assistance offices but also at health care sites frequented by low-income children and pregnant women, such as community health clinics. This allowed these providers to 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 by the state agency. *See* 42 U.S.C. § 1396a(a)(55) (added by OBRA of 1990, § 4602, 104 Stat. at 1388). Other Congresses

permitted states to allow a variety of community providers to determine "presumptive eligibility" for pregnant women, children, and breast and cervical cancer patients. 42 U.S.C. § 1396r-1 (optional presumptive eligibility for pregnant women, added in 1986); *id*. § 1396r-1a (optional presumptive eligibility for all Medicaid-eligible children, added in 1997); *id*. § 1396r-1b (optional presumptive eligibility for breast and cervical cancer patients, added in 2000).

Improving children's access to care: Congress amended the Social Security Act in 1967 to require states to cover preventive screening and treatment for Medicaid-eligible children under age 21, known as "early and periodic screening, diagnostic and treatment" (EPSDT). 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)). Over the years, Congress has maintained focus on low-income children, using budget reconciliation legislation as the vehicles for these changes. For example, in the Omnibus Budget Reconciliation Act of 1989, Congress specified separate requirements for periodic medical, vision, hearing and dental screening. Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2263-64 (adding 42 U.S.C. § 1396d(r) and amending § 1396a(a)(43)). Then, in the Omnibus Budget Reconciliation Act of 1993, Congress strengthened EPSDT to include a federally funded pediatric vaccines program. Pub. L. No. 103-66, § 13631, 107 Stat. 312, 636-45 (adding 42 U.S.C. § 1396s).

Encouraging home and community-based services: When Medicaid was first enacted, its scope of benefits

weighed heavily toward coverage of acute care services, such as inpatient hospital care and physician services. Starting in 1981, Congress revised the Medicaid Act's coverage of long-term care services to reflect the evolving national interest in allowing individuals to live in their homes and communities. *See*, *e.g.*, OBRA of 1981, Pub. L. No. 97-35, § 2176, 95 Stat. 357, 812-13 (codified at 42 U.S.C. § 1396n(c)); 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)). 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 for people with disabilities. 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.* Community-based care innovation has flourished under these federal standards, with state Medicaid programs leading the way among all insurers in developing these sites for the delivery of care. *See* Ass't Sec'y for Planning & Eval., U.S. Dep't of Health & Human Servs., *An Overview of Long-Term Services and Supports and Medicaid: Final Report* 13 (May 2018), https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf.

Protecting the at-home spouse: Congress also included "spousal impoverishment" protections for couples when one spouse is institutionalized and the

other is at home. These provisions limit the income and resources that can be counted as available to institutionalized spouses when determining their eligibility for Medicaid assistance. They are designed to protect the community spouse from becoming impoverished by the cost of the institutional care. *See*, *e.g.*, MCCA of 1988, § 303, 102 Stat. at 754-55 (adding 42 U.S.C. § 1396r-5).

Broadening the availability of outpatient prescription drugs: When Medicaid was enacted, outpatient prescription drugs were included as a Medicaid option. In significant changes, through various forms of legislation, Congress has required participating states to be involved in a broad effort to improve access to prescription drugs. For example, to control the cost of outpatient drugs, Congress amended Medicaid so that drug manufacturers must enter into rebate agreements with the federal government or with individual states in order for their drugs to be covered under the Medicaid program. OBRA of 1990, § 4401, 104 Stat. at 1338-160 (adding 42 U.S.C. § 1396r-8). And as of January 2006, states must screen all individuals who qualify for both Medicare and Medicaid and automatically enroll eligible individuals 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).

III. THE ACA MADE CHANGES TO THE MEDICAID ACT THAT BUILD UPON THE PROGRAM AS IT HAS EVOLVED SINCE 1965 AND THAT ARE ENTIRELY INDEPENDENT OF THE INDIVIDUAL MANDATE.

If the Court concludes that what remains of the minimum-coverage provision is unconstitutional, it must then determine whether it can sever that provision from the rest of the ACA. The "normal rule" is "that partial, rather than facial, invalidation is the required course." *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (remaining provisions must be retained "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of . . . the invalid part"). And as the Court noted in *New York v. U.S.*, 505 U.S. 144, 186 (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 frustrated."

The ACA contained numerous provisions aimed at improving the Medicaid program and ensuring that coverage is available and accessible to low-income people. Congress did not originally enact these provisions because of the minimum-coverage requirement. On the contrary, the Medicaid amendments in the ACA are independent of that

provision. The tax penalty is part of Title I of the ACA; the Medicaid amendments are part of Title II. 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 amendments build upon previous Medicaid Act provisions and thus address issues ranging from eligibility and covered services to quality measurement and federal funding enhancements. Repealing those provisions would have a severe impact on low-income people across the country. For example:

Coverage up to 133% of the FPL: By 2008, all participating states were required to determine Medicaid eligibility for children and pregnant women by comparing family income to a percentage of the FPL (*e.g.*, children up to age five covered up to 133% of the FPL). Eighteen states had received federal permission to extend Medicaid coverage to non-pregnant, -disabled, or -elderly adults whose incomes were below a certain percentage of the FPL. *See* Keavney Klein & Sonya Schwartz, Nat'l Acad. for State Health Poc'y, *State Efforts to Cover Low-Income Adults Without Children* 3 (Sept. 2008).

The ACA built upon this coverage by requiring states to extend Medicaid coverage to non-pregnant adults under age 65 who are not eligible for Medicare Part A or enrolled in Medicare Part B, do not fall within another mandatory Medicaid eligibility category, and have household income at or below 133% of the FPL. ACA, Pub. L. No. 111-148, § 2001(a)(1), 124

Stat. 119, 271 (2010). A conforming amendment increased the income eligibility limit for children ages 6 to 19 from 100% to 133% of the FPL. *Id.* § 2001(a)(5), 124 Stat. at 274.

As a result of *NFIB v. Sebelius*, 567 U.S. 519 (2012), states have the choice to adopt the Medicaid expansion in the first instance. To date, 37 states and the District of Columbia have opted to cover the expansion population. Kaiser Family Found., *Status of State Action on the Medicaid Expansion Decision*, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. States that expanded Medicaid have experienced reduced uninsured rates; increased access to care and use of health care services; increased affordability of care and financial security among low-income individuals; and a range of positive effects on the state economy. Madeline Guth et al., Kaiser Fam. Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (2020), https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/. Researchers have estimated that between 2014 and 2017, Medicaid expansion saved 19,200 lives. Sarah Miller et al., *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, Nat'l Bureau of Econ. Research Work Paper 26081 (2019), https://www.nber.org/papers/w26081.

Coverage of additional children involved in foster care: Building upon existing provisions regarding Medicaid coverage of children in foster care, the ACA

required states to provide Medicaid coverage to former foster care children under age 26. ACA, §§ 2004(a), 10201(a), 124 Stat. at 283, 917. The amendment ensures that the more than 20,000 young people who age out of foster care every year have access to health coverage as they pursue an education or a career and transition to adulthood. Cong. Research Serv., *Medicaid Coverage for Former Foster Youth Up to Age 26*, Congress.gov (Oct. 26, 2018), https://fas.org/sgp/crs/misc/IF11010.pdf. The majority of these young adults are people of color, mostly African-American and Latinx. U.S. Dep't Health & Hum. Servs., *Foster Care Statistics 2017* at 8 (2019), https://www.childwelfare.gov/pubPDFs/foster.pdf.

Home and community-based services options: An ACA amendment enabled states to use a state plan amendment to expand eligibility for home and community-based services to individuals whose incomes do not exceed 300 percent of the Social Security benefit rate. ACA, § 2402, 124 Stat. at 301. This change made it easier for states to provide people with disabilities access to important home and community-based services, such as case management, homemaker/home health aide and personal care, adult day health, habilitation, and respite care. As of March 2019, 13 states had taken up the option, mainly serving beneficiaries with mental illness or intellectual or developmental disabilities. MaryBeth Musumeci et al., Kaiser Fam. Found., *Key State Policy Choices About Medicaid Home and Community-Based Services* 8-9 (2020), http://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medicaid-Home-and-Community-Based-Services. In 2018, an estimated

81,000 individuals received services through this option. Molly O'Malley Watts et al., Kaiser Fam. Found., *Medicaid Home and Community-Based Services Enrollment and Spending* 5 (2020), http://files.kff.org/attachment/Issue-Brief-Medicaid-Home-and-Community-Based-Services-Enrollment-and-Spending.

The ACA Medicaid amendments also authorized states to provide home and community-based personal care attendant and support services for individuals enrolled in Medicaid who: (1) have household income up to the greater of 150 percent of the FPL or the income eligibility limit for nursing facility or equivalent services under the state plan; and (2) would require care in an institution without the services. ACA, § 2401, 124 Stat. at 297; Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1205, 124 Stat. 1029, 1056. States receive a six percent increase in their federal matching rate for the services, which must be provided according to a person-centered care plan. ACA §, 2401, 124 Stat. at 297. This provision gave states a new significant alternative to expensive institutional care for individuals who need personal care services. As of March 2019, eight states had taken up this option to cover attendant care and support services. Watts et al., *supra*, at 5.

Family planning services and supplies: The Medicaid Act requires states to cover family planning services for Medicaid-eligible individuals of reproductive age. 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a)(4)(C). The ACA Medicaid amendments gave states a new option to provide Medicaid coverage for

family planning services to non-pregnant individuals with household income below a level established by the state. ACA, § 2303(a), 124 Stat. at 293. Starting in the mid-1990s, CMS had approved demonstration projects allowing states to cover family planning services for certain individuals not otherwise eligible for Medicaid. Repeated research showed that the projects increased access to family planning services, improved contraceptive use, decreased the rate of unintended pregnancy, and reduced state spending. Adam Sonfield & Rachel Benson Gold, Guttmacher Inst., *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future* (2011), https://www.guttmacher.org/sites/default/files/report_pdf/medicaid-expansions.pdf. With ACA Section 2303, Congress enabled states to provide eligibility for family planning services through their state Medicaid plans. To date, 17 states have taken up the option, giving millions of people access to essential reproductive health care. Guttmacher Inst., Medicaid Family Planning eligibility Expansions (updated Apr. 1, 2020), https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions#.

Expanded opportunities for presumptive eligibility: The ACA Medicaid amendments required states to allow hospitals to determine presumptive eligibility for Medicaid. ACA, § 2202(a), 124 Stat. at 291. Individuals found eligible receive Medicaid coverage on a temporary basis pending a final determination of their eligibility by the state. As noted, prior to the ACA, states had the option to permit health care providers to use presumptive eligibility to connect children, pregnant people, and certain individuals with breast or

cervical cancer, to Medicaid. *See* 42 U.S.C. §§ 1396r-1, 1396r-1a, 1396r-1b. ACA Section 2202 gave hospitals the opportunity to connect other populations to Medicaid, ensuring that they receive timely access to care. The provision also promotes permanent coverage by providing individuals with an additional way to apply for Medicaid. Ctrs. for Medicare & Medicaid Servs., *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (2014), https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/faqs-by-topic-hospital-pe-01-23-14.pdf.

Expanded spousal impoverishment protections: Section 2402 of the ACA protects a certain amount of a married couple's income and assets when one spouse is receiving home and community-based long-term services and supports, to ensure that the other spouse has sufficient income for living expenses. Without such protections, the expense of long-term services and supports—which can cost upwards of $5,000 a month—can rapidly deplete lifetime savings. As described above, Congress previously enacted provisions to prevent spousal impoverishment when one spouse resides in a long-term care institution. The ACA amendment required states to provide protections for couples receiving a wide range of long-term services and supports through 2018. Congress has subsequently extended the protections multiple times, and they are currently set to expire on November 30, 2020. *See, e.g.*, Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, § 3812 (2020) (codified as note under 42 U.S.C. 1396r-5).

Additional protections for children: The ACA Medicaid amendments specify that children in Medicaid (and CHIP) who receive coverage for hospice care do not waive their right to receive coverage for curative or life-prolonging therapies. ACA, § 2302(a), 124 Stat. at 293. Prior to the ACA, both children and adults who elected hospice care were forced to forgo coverage for treatment of their terminal conditions. 42 U.S.C. § 1396d(o)(1). Parents were thus forced to make a "'terrible' and unacceptable choice between curing a child's disease and giving up hope." Lisa C. Lindley, *Health Care Reform and Concurrent Curative Care for Terminally Ill Children: A Policy Analysis*, 13 J. Hosp. Palliative Nursing 81 (2011). The concurrent care provision in the ACA eliminated that barrier to accessing hospice services for children, allowing them to receive better quality end of life care.

Coverage at freestanding birth centers: The ACA builds upon the sites where people can obtain needed care through Medicaid. It requires states to cover services provided at freestanding birth centers, which are facilities (other than a hospital) licensed by the state to provide prenatal, labor and delivery, or post-partum care. ACA, § 2301, 124 Stat. at 292. Research shows that receiving services at freestanding birth centers is associated with improved maternal and child health outcomes and lower costs. Ctrs. for Medicare & Medicaid Servs., *Joint Informational Bulletin: Strong Start for Mothers and Newborns initiative* (Nov. 9, 2018).

Home health for the chronically ill: The ACA Title II provisions allow states to amend their state plans to

provide care to certain individuals with chronic conditions through a health home. ACA, § 2703, 124 Stat. at 319. Health home services include care management, care coordination and health promotion, transitional care, patient and family support, referral to community and social support services, and use of health information technology to link services. *Id.* § 2703(h)(4), 124 Stat. at 321. Congress incentivized states to adopt health homes, providing an enhanced federal matching rate during the first eight quarters in which the services are covered and making planning grants available to states. *Id.* § 2703(c), 124 Stat. at 319. The provision gave states another tool to coordinate and integrate care for Medicaid enrollees with significant health care needs. Office of the Ass't Sec'y for Planning and Evaluation, U.S. Dep't of Health & Human Servs., *Report to Congress on the Medicaid Health Home State Plan Option* 15 (2018) ("State officials and providers in the first 11 states to implement the health home program report that the model has served the targeted, high-need chronic condition populations well and has shown improvements in care management, care transitions, behavioral health integration, and linkages to services to address the social determinants of health."). As of 2019, twenty-two states had established these health homes. Kaiser Family Found., *States that Reported Health Homes in Place*, https://www.kff.org/medicaid/state-indicator/states-that-reported-health-homes-in-place/.

Demonstration grants for home and community-based care: The ACA Medicaid amendments extended and expanded the Money Follows the Person (MFP) Rebalancing Demonstration program. ACA, § 2403, 124

Stat. at 304. The Deficit Reduction Act of 2005 directed the Secretary of HHS to award MFP Rebalancing Demonstration grants to states to provide home and community-based services to individuals who had been residing in an inpatient facility. Section 2403 of the ACA extended this program for five years and reduced the minimum amount of time the person had to have resided in an institution to be eligible. States used the grants provided for by the ACA to move over 75,000 seniors and people with disabilities from institutional settings. Mathematica Policy Res., *Money Follows the Person Demonstration* 7 (Sept. 25, 2017), https://www.medicaid.gov/sites/default/files/2019-12/2016-cross-state-report.pdf. Congress has subsequently extended the program multiple times; it now runs through November 2020. Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, § 3811 (2020) (codified as note under 42 U.S.C. § 1396a).

Measuring quality of care: The ACA required the Secretary of Health and Human Services to develop and publish a recommended core set of health quality measures for adults eligible for Medicaid. ACA, § 2701(a)-(b), 124 Stat. at 317. The provision, which built on an earlier-enacted provision regarding health quality measures for children, *see* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 1139A, 123 Stat. 8, 72-82, also required states to report to the Secretary the specific quality measures they use and the quality of health care furnished to Medicaid-enrolled adults. ACA, § 2701(d), 124 Stat. at 318. The Secretary must make that information available to the public. *Id.* The provision has helped to improve oversight and accountability of

state Medicaid programs. States' use of the core set has increased over time, with 32 states reporting on at least half of the recommended measures in 2018. Ctrs. for Medicare & Medicaid Servs., *Fact Sheet: Quality of Care for Children and Adults in Medicaid and CHIP: Overview of Findings from the 2018 Child and Adult Core Sets*, 1 (Sept. 2019), https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/ffy-2018-core-set-reporting.pdf.

Outpatient prescription drug coverage: The ACA established a new rebate formula for Medicaid prescription drugs, which increased the minimum rebate percentage for most outpatient prescription drugs. ACA, §§ 2501, 2503, 124 Stat. at 306, 310. The statute also allowed states to obtain rebates for Medicaid beneficiaries who receive their drugs through a managed care plan; previously, rebates were only available to states for their fee-for-service Medicaid beneficiaries. This change increased the amount of funding to the federal Medicaid program: in 2017, Medicaid generated $34.9 billion in rebates, compared to $19.9 billion in 2014. Medicaid & CHIP Payment & Access Comm'n, *Medicaid Drug Spending Trends* 1 (2019), https://www.macpac.gov/wp-content/uploads/2019/02/Medicaid-Drug-Spending-Trends.pdf.

The ACA also eliminated a categorical exclusion on Medicaid coverage of three classes of drugs for their medical uses starting in 2014: over-the-counter smoking cessation drugs, barbiturates, and benzodiazepines. ACA, § 2502, 124 Stat. at 310. The provision ensured that beneficiaries have access to

these important medications to treat serious conditions like tobacco use, insomnia, and substance use disorders.

Coverage of Medicare-Medicaid dual eligibles: The ACA created a new office at the federal Centers for Medicare & Medicaid Services charged with better integrating Medicaid and Medicare for beneficiaries enrolled in both programs. ACA, § 2602, 124 Stat. at 315. The Office has worked to align benefits for duals, helping coordinate and align acute care and long-term care services. It also oversees pilot programs that test innovative models aimed at improving the quality of care while slowing the rate of cost growth in Medicare and Medicaid. If a pilot model is deemed successful based on certain criteria, the Secretary of Health and Human Services may expand its duration and scope. To date, the Office has identified two models for expansion: the Pioneer Accountable Care Organization Model and the Medicare Diabetes Prevention Program. Ctrs. for Medicare & Medicaid Servs., CMMI Model Certifications, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/CMMI-Model-Certifications.

Funding for territories: Unlike the states and the District of Columbia, the territories have a fixed matching rate and a cap on total federal Medicaid funding. The ACA increased federal Medicaid funding for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa from 50% to 55%. ACA, § 2005, 124 Stat. at 283.

Funding during disasters: An ACA Title II provision allowed for an increase in the federal

matching rate for states recovering from a major statewide disaster. As a result of this change, Louisiana received additional federal Medicaid funding as it recovered from Hurricane Gustav. *See* 76 Fed. Reg. 74061, 74062 (Nov. 30, 2011); 77 Fed. Reg. 71420, 71423 (Nov. 30, 2012).

CONCLUSION

No matter what it does with the ACA's minimum-coverage provision, the Court should preserve the improvements the ACA has made to the Medicaid program.

Respectfully submitted,

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