No. 11-398

In The Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Petitioners,

v.

STATE OF FLORIDA, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF CHILD ADVOCACY ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS ON THE MINIMUM COVERAGE PROVISION QUESTION

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BRIEF OF CHILD ADVOCACY ORGANIZATIONS AS *AMICI CURIAE*

This brief is submitted on behalf of various child advocacy centers and child health projects for the purpose of informing the Court about the perspective of children in this case.[1]

INTEREST OF *AMICI CURIAE*

A. The Barton Child Law and Policy Center at Emory School of Law

The Barton Child Law & Policy Center is a clinical program of Emory Law School dedicated to promoting and protecting the legal rights and interests of children involved with the juvenile court, child welfare and juvenile justice systems in Georgia. The Center achieves its reform objectives through research-based policy development, legislative advocacy, and holistic legal representation for individual clients. The Barton Center's children's rights agenda is based on the belief that policy and law should be informed by research and that legal service to children and families need to be holistic. The premise

[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae,* its members, or its counsel made a monetary contribution to its preparation or submission. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

behind representing the "whole" child exists at the core of the Barton Center's mission and our approach to student instruction. That basis recognizes that children should be viewed in their social and familial contexts and provided with individualized services to protect their legal rights, respond to their human needs, and ameliorate the social conditions that create risk. The Barton Center adopts an interdisciplinary, collaborative approach to achieving justice for youth.

The Barton Center has engaged in policy and legislative advocacy to promote children's rights since it was founded in March 2000. The Barton Center currently houses the Barton Public Policy and Legislative Advocacy Clinic, the Barton Juvenile Defender Clinic, and the Appeal for Youth Clinic, allowing us to provide a voice for youth issues through individual representation and systemic reform advocacy. Legal services provided by the Barton Center are provided at no cost to our clients. The work of the Barton Center is funded by Emory Law School, private gifts, foundation grants, and contracts with a variety of organizations.

B. The Juvenile Law Center

The Juvenile Law Center, founded in 1975, is the oldest public interest law firm for children in the United States. Juvenile Law Center advocates on behalf of youth in the child welfare and criminal and juvenile justice systems to promote fairness, prevent

harm, and ensure access to appropriate services. Recognizing the critical developmental differences between youth and adults, Juvenile Law Center works to ensure that the child welfare, juvenile justice, and other public systems provide vulnerable children with the protection and services they need to become healthy and productive adults. Juvenile Law Center works to ensure that the juvenile justice and child welfare systems be used only when necessary and that children and families served by those systems receive high-quality and evidence-based physical and mental health care and that those services be provided in the community whenever possible. Juvenile Law Center participates as *amici curiae* in state and federal courts throughout the country, including the United States Supreme Court, in cases addressing the rights and interests of children.

C. The University of Florida's Center on Children and Families

The Center on Children and Families (CCF) at the University of Florida Fredric G. Levin College of Law in Gainesville, Florida is an organization whose mission is to promote the highest quality teaching, research and advocacy for children and their families. CCF's directors and associate directors are experts in children's law, constitutional law, criminal law, family law, and juvenile justice, as well as related areas such as psychology and psychiatry. CCF supports interdisciplinary research in areas of importance to children, youth and families, and promotes child-centered,

evidence-based policies and practices in dependency and juvenile justice systems. Its faculty has many decades of experience in advocacy for children and youth in a variety of settings, including the Virgil Hawkins Civil Clinics and Gator Team Child juvenile law clinic.

D. Emory University's Vulnerability and the Human Condition Initiative

The Vulnerability and the Human Condition Initiative (VHC) is located at Emory University in Atlanta, Georgia. VHC supports interdisciplinary research exploring the nature and policy implications of human and institutional vulnerability. Scholars associated with the Initiative are experts in health, poverty, family and children's law, constitutional law, criminal law, and juvenile justice, as well as general areas such as torts and contracts. Of particular concern to VHC scholars are the ways in which responses to shared human vulnerability are structured through the creation of societal institutions, particularly when such institutional arrangements privilege some and disadvantage others. VHC has national and international affiliations and hosts visiting scholars from around the world, as well as holding several yearly workshops and conferences.

E. The Child Rights Project

The Child Rights Project (CRP) is a project of Emory Law School engaging students in researching

and writing friend of the court briefs in cases of importance to children and youth. Its mission is to highlight for the judiciary and the public the often unanticipated impact of court decisions on children, our most vulnerable citizens. The CRP's goal is to train new generations of lawyers in multidisciplinary research and advocacy. The CRP collaborates with distinguished law firms to provide pro bono representation to an underserved population. Leadership of the CRP has over twenty-five years of experience in appellate advocacy on behalf of children.

F. The Civitas ChildLaw Center of Loyola University Chicago School of Law

The Civitas ChildLaw Center is a program of the Loyola University Chicago School of Law, whose mission is to train law students, attorneys and child welfare professionals to be effective advocates for children, to influence policy and legislative reforms to improve the lives of children and families, and to promote justice for children and families through interdisciplinary teaching, scholarship and service. The ChildLaw Policy Institute, within the ChildLaw Center, works to promote child-centered laws, policies and practices, and focuses on a broad range of policy projects designed to improve children's health, safety, and well-being and maintains an interest in the policies and practices at the state and federal level that impact children and youth, including those aging out of foster care. Among the faculty of the ChildLaw Center are academics, lawyers and scholars who have

litigated, taught, consulted and written extensively in the area of child and family well-being for several decades.

G. The Health Justice Project at Loyola University Chicago School of Law

The Health Justice Project at Loyola University Chicago School of Law is a medical-legal partnership in which law students and attorneys collaborate with social workers, public health students, and community health care providers to identify and address social and legal issues that negatively impact the health of low-income patients. Once identified, law students and pro bono attorneys in the Health Justice Project provide legal representation, advice, and referrals to remedy the legal and social issues that negatively impact health. Advanced Health Justice Policy, within the Health Justice Project, focuses on policy projects designed to improve the health of vulnerable, low-income populations. Among the faculty of the Health Justice Project are academics and lawyers who have litigated, taught, consulted, and written in the area of health of low-income populations.

H. Center for the Human Rights of Children

The Center for the Human Rights of Children (CHRC) is a University Center of Excellence at Loyola University Chicago, whose mission is to represent, coordinate, and stimulate efforts to understand,

protect and apply the human rights of children. The CHRC focuses on a broad range of projects and initiatives advancing children's political, social, economic, and civil rights, and maintains a particular interest in policies and practices at the state and federal level that impact access to appropriate services to advance children's health and well-being. Among the affiliated faculty of the CHRC are scholars who have taught, consulted, advocated, and written extensively in the area of child rights, and child and family health and well-being for several decades.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA") extends and expands the delivery of health care of vital importance to America's children. The minimum coverage provision enacted by elected policy makers ensures that its comprehensive reforms to the health insurance system are feasible and sustainable.

Unlike adults, children have little or no control over their access to care or the purchase of health insurance. Prior to the enactment of the ACA, health care insurance was unavailable and unaffordable to millions of Americans, including children. A primary purpose of the ACA is to ensure that quality and affordable health care would be accessible to the most vulnerable populations, including children. Despite

programs such as Medicaid and CHIP, an estimated half of children with special health care needs lacked access to the type of comprehensive health care necessary to promote optimal child outcomes. Private health insurance had become ever more expensive and increasingly narrow, leaving families unable to afford or unable to obtain insurance because children were disqualified as a result of preexisting conditions or caps on coverage.

The ACA reflects a series of legislative policy choices addressing the commercial insurance market's failure to provide an affordable health care insurance product for many children and their families. It enables parents to access affordable coverage through health "exchanges," and it increases access to "child-only" policies to assure all children are covered. It forbids job-based health plans and new individual plans to deny coverage for children under age 19 based on a preexisting condition, including a disability.

The ACA also increases access to insurance for young adults. For children with special health care needs transitioning from child to adult care, this regulatory intervention into the insurance markets facilitates the delivery of essential continuous care. In addition, the ACA includes special provisions to assure continuity of coverage for youth who are leaving the foster care system. Aging out of foster care often means aging out of health care, a gap that is particularly onerous for foster care youth because

half of all foster care youth have chronic medical problems.

The ACA enhances the accessibility of preventive care by prohibiting insurers from placing cost-sharing requirements on certain forms of preventive care. The ACA recognizes that prenatal care for mothers is an essential element in assuring a child's healthy development. Indeed, the health of the mother impacts the child for life because the vast majority of brain cells are formed in utero in the second and third trimesters. The elected policy makers' decision to expand insurance coverage for women's preventive health care secures healthier infant birth weights and diminishes rates of disability and morbidity. The ACA provides for screenings and services that span the preconception, prenatal, and postpartum periods.

The ACA also makes recommended immunizations against childhood diseases more available and affordable. The ACA requires health insurance providers to make available, at no additional cost, evidence-informed preventive care and screenings for infants, children, and adolescents. Preventive health care measures range from screening for developmental delays and obesity screening to drug and alcohol abuse counseling. ACA preventive care also extends to oral health risk assessment and appropriate follow-up care. The ACA also makes early detection and screening of children's health status more available and affordable. The screenings provided for by ACA promote early detection and treatment of heritable

disorders in newborns and children, and saves children's lives.

The ACA provides for innovative programs to deliver health care to children in their own homes and communities and at their schools. The ACA provides school-based health centers to deliver convenient, quality care to children. It recognizes that education and health are closely linked. Children who suffer from health problems are substantially less likely to complete high school and transition to post-secondary education. School-based health centers increase access to health care for many of those who need it most, including underserved adolescents, a population long considered difficult to reach.

The ACA provides for home visitation programs. Home visitation has been recognized for its potential to foster early child development and competent parenting, as well as to reduce risk for child abuse and neglect and other poor outcomes for vulnerable families. ACA funding helps to jumpstart promising initiatives in maternal and early childhood health, the benefits of which are long-term and substantial. The judicial removal of such provisions would be to the detriment of state-based early childhood home visitation programs across the country and would destroy many opportunities for further research.

Recognizing a growing problem that threatens the health of our citizenry, the ACA also provides funding for efforts to combat childhood obesity. Grants to schools, recreation facilities, daycare

facilities, and other community organizations, as well as programs aimed at parents and educators, will have long-term and substantive benefits.

The ACA represents a leap forward in children's access to affordable quality health care. Its expansion of health care delivery to children generally, and especially to those with special health care needs, is a rational and appropriate policy decision well within Congress' power under the Commerce Clause to regulate the nationwide market for health services and to address the market's failure to advance and to protect the health of America's children.

ARGUMENT

I. CONGRESS HAS THE POWER UNDER THE COMMERCE CLAUSE TO ENACT THE MINIMUM COVERAGE PROVISION.

This is not the first instance in which the Court has been asked to curtail an effort by Congress to address the vital interests of children through the exercise of its Commerce Clause powers. *See* U.S. Const. art. I, sec. VIII, par. III. In 1918, the Court was invited to invalidate federal legislation regulating the hours and working conditions of child laborers. The Court concluded that Congress lacked the power to address the exploitation of America's children in factories, mines and mills. *Hammer v. Dagenhart*, 247 U.S. 251 (1918). Justice Holmes, in

dissent, wrote: "[I]f there is any matter upon which civilized countries have agreed . . . it is the evil of premature and excessive child labor. . . . It is not for this Court to pronounce when . . . [regulation] is permissible as against strong drink but not as against the product of ruined lives." *Hammer*, 247 U.S. at 280. The Holmes dissent ultimately prevailed. The Court recognized its error – twenty-three years later – in *United States v. Darby Lumber Co.*, 312 U.S. 100, 115 (1941).

Legislative authority to protect children under the Commerce Clause is not limited to child labor laws.[2] Children deprived today of adequate health care, much like Reuben Dagenhart – whose health was destroyed by breathing dust and shouldering heavy loads as a child – are condemned to live with the life-long consequences of decisions made by others. Barbara Bennett Woodhouse, *Who Owns the Child?*: Meyer *and* Pierce *and the Child as Property*, 33 WM. & MARY L. REV. 995, 114-115 & n. 653 (1992).

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA") is of special importance to the nation's children. The Congressional Budget Office has projected that the

[2] *See*, *e.g.*, 18 U.S.C. § 2251-60 (federal laws against child pornography and child sex exploitation). In addition to the Commerce Clause, *amici* believe that the ACA is a proper exercise of other legislative authority conferred by Article I of the Constitution, including Congress' powers under the taxing, spending, and necessary-and-proper clauses. *See* U.S. Const. art. I, sec. VIII, par. I & par. XVIII.

ACA will reduce the number of non-elderly individuals without insurance by about 33 million by 2017. *CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained In the Patient Protection and Affordable Care Act* 1 (Mar. 18, 2011). The elected policy makers who enacted this legislation acted within the scope of their constitutional authority to advance and to protect the health and wellbeing of America's children.

II. PRIOR TO THE ENACTMENT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, HEALTH CARE INSURANCE WAS UNAVAILABLE AND UNAFFORDABLE TO MILLIONS OF AMERICANS, INCLUDING CHILDREN.

Congress passed the ACA to address a cluster of severe societal problems caused by the inability of millions of Americans to afford health insurance or to obtain necessary health care. Among Congress's primary concerns was the health and wellbeing of children, who are especially vulnerable due to their inability to purchase health care themselves or to make mature decisions regarding their health. Children rely entirely on adults to procure health insurance for them, but for many families, affordable health care insurance for their children has not, until now, been within their financial means. As a result, children have been left without necessary preventive treatment and medical care.

In 2009, nearly eight million children did not have health insurance. Children's Defense Fund, *Who Are the Uninsured Children: Profile of America's Uninsured Children* 1 (Jan. 2011). Of those eight million children, 68.2 percent came from families with incomes greater than 100 percent of the federal poverty line.[3] *Id.* Consequently, those families earned too much to qualify for government-funded health care coverage, but too little to afford private insurance. The remaining 31.8 percent of children came from families with incomes at or below 100 percent of the federal poverty line. *Id.* For those children, Medicaid, a state and federally funded cooperative health care program, provided subsidized or extremely low-cost health care. Henry J. Kaiser Family Foundation, *Medicaid and Children's Health Insurance Provisions in the New Health Reform Law* 1 (Apr. 7, 2010).

Until recently, Medicaid only covered children under the age of six with family incomes below 133 percent of the federal poverty line and children age 6 to 18 with family incomes below 100 percent of the federal poverty line. Andy Schneider et al., The Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book* at 131 (2002). Medicaid is jointly funded by state and federal governments, but each state administers its own Medicaid program. Federal oversight of state-run programs is administered by the Centers for Medicare and Medicaid

[3] In 2009, a family of four living at the federal poverty line earned an annual income of $22,050. 74 Fed. Reg. 4199, 4200 (January 23, 2009).

Services, which also establishes eligibility standards and requirements for service, including delivery, quality, and funding. Barbara S. Klees et al., Office of Retirement and Disability Policy, *Annual Statistical Supplement* (Nov. 1, 2010).

Before the adoption of ACA, Congress tried temporarily and unsuccessfully to subsidize families with modest incomes who did not qualify for Medicaid assistance. Children whose family incomes exceed the eligibility standards for Medicaid may be eligible to receive benefits through Children's Health Insurance Programs ("CHIPs"), which are administered by the Department of Health and Human Services. Like Medicaid, CHIPs are jointly funded by state and federal governments, and limited oversight is conducted by the Centers for Medicare and Medicaid Services, Medicare & Medicaid Services. *Children's Health Insurance Program (CHIP)*, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html (last visited January 10, 2012). Broad federal guidelines have yielded inconsistent state-by-state applications, with each state having a different system. Kristine Goodwin et al., *The Children's Health Insurance Program: A Primer for State Legislatures* at 2 (2009). All fifty states and the District of Columbia operate CHIPs. *Id.*

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), Pub. L. No. 111-3, 123 Stat. 8 (2009) reauthorized CHIPs to extend

benefits to fiscal year 2013. Anna C. Spencer, *Express Lanes, Premium Assistance and Contingency Funds: The New Provisions in CHIPRA,* 30 STATE HEALTH NOTES 541 (June 22, 2009). CHIPRA allowed the states to expand their Medicaid programs, to combine CHIPs with current Medicaid programs, or to create separate CHIPs. *See* Goodwin, *supra* at 11. A state which created a separate CHIP may also impose cost-sharing, tailor their benefit packages, and employ flexibility in eligibility and enrollment matters. 42 C.F.R. pt. 457 (2010).

After CHIPRA, 12 states and the District of Columbia expanded their Medicaid programs, 21 states combined CHIPs with Medicaid, and 17 states created separate CHIPs. Martha Heberlein et al., Kaiser Commission on Medicaid and the Uninsured & Georgetown University Center for Children and Families, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP* at 29 (2010). As of January 2011, half of the states increased the amount of children they cover and provided affordable coverage options to children in families with income at or above 250 percent of the federal poverty line. Kaiser Commission on Medicaid and the Uninsured, *Where are States Today? Medicaid and CHIP Eligibility Levels for Child and Non-Disabled Adults* at 1 (2011). Four states expanded the eligibility threshold to less than 200 percent of the federal poverty line. *Id.*

CHIPRA has allowed the states to make children's health care more affordable and available. However, CHIPRA is only authorized to continue through 2013. Spencer, *supra* at 541. Even with the expansions permitted by CHIPRA, five million to six million children may remain uninsured because of eligibility requirements and the unaffordability of private insurance. Judith S. Palfrey, *How Health Care Reform Can Benefit Children and Adolescents*, 34 NEW ENG. J. MED. 361:e34 (Oct. 22, 2009).

Pre-ACA efforts to facilitate affordable and quality health care for children proved, in the judgment of Congress, inadequate. CHIPs assist many low-income families with providing children with the health care they need. However, non-qualifying families must continue to rely on private insurance or employer-sponsored plans, which are often unaffordable and insufficiently comprehensive. Between 2009 and 2011, the cost of maintaining private health insurance skyrocketed. Total premiums for families with employer-sponsored plans increased from $5,791 to $15,073, an increase of over $9,000. Gary Claxton et al., Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2011 Annual Survey* at 13 (2011).

Private insurance coverage also requires significantly more out-of-pocket costs, such as co-payments, coinsurance, and deductibles. Genevieve M. Kenney & Stan Dorn, Health Policy Center of the Urban Institute, *Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize*

Gains & Prevent Harm? Timely Analysis of Immediate Health Policy Issues at 3 (2009). Prior to the adoption of ACA, such plans also included both annual and lifetime caps on covered benefits, requiring families to pay very high costs if children experience serious health problems. *Id*. at 5. Additionally, private insurance has often been narrower than what is offered by public insurance, and thus often has not included critical preventive and early diagnosis care, a medical necessity that promotes the healthy physical, behavioral, and emotional development of children. *Id.* at 3.

In 2005, despite the limited availability of Medicare and CHIPs assistance, over 12 percent of children with special health care needs were uninsured for some period of time during that year. Kathleen Farrell et al., National Academy for State Health Policy for the Catalyst Center, *The ACA and Children with Special Health Care Needs: An Analysis and Steps for State Policymakers* at 9 (Jan. 2011). Gaps in coverage are particularly problematic for children with special health care needs:

> Approximately one of every seven children under 18 years of age, or 14 percent of children in the United States, has a special health care need. Children with special health care needs have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and also require health and related services of a type or amount far greater than required by children generally . . . With advances in medical

> treatment, children with some of the most complex conditions are now surviving well into adulthood, so that transition from child to adult coverage systems has become a critical issue.

Id. at 8.

Children with special health care needs often demand such a high level of care that parents must quit their jobs to care for their children. This can result in reduced income or loss of employer-based insurance. *Id*. at 10.

One study found that, "[a]lthough most [children with special health care needs] have a usual source of care, some do not, and approximately one half do not have access to the type of comprehensive health care necessary to promote optimal child outcomes." Bonnie B. Strickland et al., *Access to the Medical Home: New Findings from the 2005-2006 National Survey of Children with Special Health Care Needs*, 123 PEDIATRICS e996, e1001 (2009). "These findings reinforce the need to continue and to expand federal, state, and community efforts to eliminate disparities in access to care." *Id.* This myriad of gaps in coverage for children contributed to Congress' decision to finally address the dire problems existing in health care with the ACA.

III. THE ACA MAKES QUALITY HEALTH CARE INSURANCE MORE AFFORDABLE AND AVAILABLE FOR CHILDREN.

The ACA helps to fill the gaps that exist in health care coverage for children and their families. The ACA includes many provisions that recognize the special vulnerability of children and ensures the provision of affordable and quality health care for children.

In providing access to health care, the ACA prohibits health insurers from excluding coverage of preexisting conditions for children. 42 U.S.C. § 300gg. It also seeks to remedy the lack of children's health care services in private health care plans by requiring basic pediatric services under all plans, including oral and vision care. 42 U.S.C. § 293k. Further, the ACA also requires health insurers to cover low-cost preventive services. 42 U.S.C. § 300u-11.

In addition to requiring basic pediatric services and preventive care, the ACA expands the health care workforce to include more pediatric professionals. 42 U.S.C. §§ 293k, 293k-2. For families without job-based coverage, the ACA allows those families to opt-in to allow their children to receive health care services. The ACA provides a tax credit to families who would otherwise be unable to afford insurance through state-based health insurance "exchanges." 42 U.S.C. §§ 18031, 18044, 18083. The exchanges are designed to foster competition and increase consumer choice, allowing for better coverage and

lower expenses. Nat'l Ass'n of County & City Health Officials, *Health Reform and Local Health Departments Webinar* (Apr. 13, 2010), *available at* http://www.naccho.org/advocacy/healthreform/aca.cfm (last visited January 10, 2012). The ACA also ensures that children will have access to affordable child-only insurance policies, regardless of whether their parent moves, changes jobs, leaves a job, or becomes disabled. 42 U.S.C. § 2707.

For children who rely on government-funded health care programs, such as Medicaid and CHIP, the ACA expands the provision of public medical services. The ACA extends federal funding of CHIPs for an additional two years to September 30, 2015, and provides states with additional funding to ensure children have access to this proven successful program. 42 U.S.C. §§ 1397(dd)-(ee). The Act provides health care insurance for children aging out of foster care, making mandatory the current State option to extend Medicaid coverage up to age 26 to foster children who have aged out of the foster care system. 42 U.S.C. § 1396(a)(10)(A)(i)(IX).

A. The ACA extends health care insurance coverage to all children, including children with special health care needs and children aging out of the foster care system.

The ACA provides significant benefits to children with special health care needs and children aging out of the foster care system, children who are uniquely

vulnerable and have been historically deprived of needed health care services. The ACA assists these groups with the crippling costs of health care. Assisting with these costs earlier in life can often lower the burden that these groups place on health care providers and insurers later in life if they are not properly treated at a young age. A ruling that eliminates these benefits in the ACA would be detrimental to children with special health care needs and children aging out of foster care.

1. The ACA increases coverage to children with preexisting conditions and disabilities.

The enactment of the ACA had powerful and important implications for children with preexisting conditions and children with disabilities. These children are often referred to as children with special health care needs. In January 2011, the National Academy for State Health Policy for the Catalyst Center urged lawmakers to pass the ACA in order to address the needs of the "approximately 10.2 million children with special health care needs in this country, with a wide array of diagnoses." Farrell, *supra* at 8. For children with special health care needs, costly and comprehensive care is often necessary. The ACA protects children with special health care needs by preventing insurers from capping benefits and mandating that essential benefits are provided. "The Affordable Care Act prohibits health plans from putting a lifetime dollar limit on most benefits . . .

and does away with these limits entirely in 2014." *Affordable Care Act for Americans with Disabilities,* HealthCare.gov*, http://www.healthcare.gov/news/factsheets/2010/11/affordabale-care-act-americans-disabilities.html*; *see also Catalyst Center, Affordable Care Act: A Side-by-Side Comparison of Major Provisions and the Implications for Children and Youth with Special Health Care Needs* (Feb. 2011). According to the article released by the National Academy for State Health Policy, "Over 33 percent of families of [children with special health care needs] report their health coverage is inadequate in regard to whether their children can see the providers they need, whether needed benefits are covered, and whether uncovered costs are reasonable." Farrell, *supra* at 9.

The ACA addresses this need in part by mandating that insurers cover certain essential benefits, including ambulatory patient services, emergency services, hospitalization, laboratory services, maternity and newborn care, pediatric services including oral and vision care, preventive and wellness services, as well as chronic disease management, rehabilitative and habilitative services and devices, prescription drugs, and mental health and substance abuse services. *Affordable Care Act: A Side-by-Side Comparison,* supra at 7. The minimum coverage provision is an integral part of the law and makes this scheme feasible. Without the minimum coverage provision, these provisions of vital importance to children with special health care needs will fail and these protections will be lost.

The ACA increases access to health care for children with special health care needs, specifically those with preexisting conditions who have historically been denied coverage. The cost of care for these children can be crippling for a family if the child is denied insurance due to the child's preexisting condition. Under the ACA, "Job-based health plans and new individual plans are no longer allowed to deny or exclude coverage for [children under age 19] based on a preexisting condition, including a disability." *Families with Children and the Affordable Care Act*, HealthCare.gov, http://www.healthcare.gov/news/factsheets/2011/08/families.html (last visited Jan. 10, 2012); *see also Affordable Care Act: A Side-by-Side Comparison, supra* at 4; 42 U.S.C. § 300gg. This provision carries great importance for children with special health care needs. In 2008, insurers denied over 20,000 children's applications due to preexisting conditions. *Affordable Care Act: A Side-by-Side Comparison, supra* at 4. Farrell, *supra* at 14. The ACA increases access to preventive care for children with special health care needs by ensuring that those under 19 are not denied coverage. This investment in preventive care can lower costs to public and private insurers as well as individuals by decreasing the need for costly treatments for illness and disease that have gone untreated. *Affordable Care Act for Americans with Disabilities*, HealthCare.gov (Nov. 16, 2010), (last visited Jan. 10, 2012), http://www.healthcare.gov/news/factsheets/2010/11/affordable-care-act-americans-disabilities.html.

The ACA increases access to insurance for young adults, which is of great importance to Children with Special Health Care Needs transitioning from child to adult care, a population for whom continuous care is essential. Farrell, *supra* at 8. Under the ACA, young adults who are not eligible for employer-based coverage are entitled to remain covered by their parents' insurance plan until age 26. *Health Care Reform for Children, supra*. During this transitional period in young adults' lives, they may not yet be eligible for comprehensive employer-based care. And, for children with special health care needs, they may not have sufficient income to purchase the needed coverage independently. Until 2014, insurers may continue denying or limiting coverage for Americans with disabilities over the age of 19. *Affordable Care Act: A Side-by-Side Comparison*, *supra* at 4. Allowing young adult children with special health care needs to gain coverage through their parents' insurance will help ensure continuing care for the transition to adult care. *Id.*; *Families with Children*, *supra*. States have the option to expand coverage in this way effective immediately with the expansion becoming mandatory in 2014. *Health Care Reform for Children*, *supra*.

2. The ACA ensures that all children have access to affordable, quality, essential health care coverage, particularly those children aging out of foster care.

Many children who age out of foster care also age out of health care. John Reiss & Robert Gibson,

Health Care Transition: Destination Unknown, 110 PEDIATRICS 1307 (2002); John Reiss, Robert Gibson & Leslie Walker, *Health Care Transition: Youth, Family, and Provider Perspectives*, 115 PEDIATRICS 112 (2005). Many foster children will remain in foster care until they reach the age of majority, and "the odds of moving easily into independence are stacked against" them. Richard P. Barth, *On Their Own: The Experiences of Youth After Foster Care*, 7 CHILD AND ADOLESCENT SOCIAL WORK 419 (1990). Aging out of health care is particularly problematic for foster care youth because half of all foster care youth have chronic medical problems. Robin Mekonnen et al., *Achieving Better Health Care Outcomes for Children in Foster Care*, 56 Pediatric Clinics of North America 405 (2009). Of the some 400,000 children in foster care, many face multiple barriers to adequate health care. *AFCARS Report – Preliminary FY 2010 Estimates as of June 2011 (18)*, Administration for Children & Families, Department of Health & Human Services, *available at* http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/ report18.htm; *see* Mark D. Simms et al., *Health Care Needs of Children in the Foster Care System*, 106 PEDIATRICS 909 (2000).

Because so many older foster children leave foster care "in a rush and with no feasible living plans," including health plans, Barth, *supra*, the federal government has responded with initiatives such as Congress' 1986 Transitional Independent Living Program for Older Foster Children, Pub. L. No. 99-272 § 12307 (1986). The ACA continues the

goal of providing foster care youth with a healthy transition from pediatric to adult care. Under the ACA, states must extend Medicaid coverage up to age 26 to foster children aging out of the system by 2014. 42 U.S.C. § 1396a(a). This provision will provide foster children with quality, affordable health insurance, one of the challenges children face when aging out of the foster care system.

These challenges have been recognized before by the federal government. The Fostering Connections to Success and Increasing Adoptions Act of 2008 ("FCSIAA") requires states to develop an oversight and coordination plan regarding health care services for children in foster care. The ACA builds on the FCSIAA, requiring that the transition plan include information on options for health insurance and on the importance of designating another individual to make health care treatment decisions on behalf of the child if he or she becomes unable to do so. 42 U.S.C. §§ 622(b)(15)(A), 675(5)(H), 677(b)(3).

Providing additional information about the complexities of health insurance and of making treatment decisions is an important part of this transition out of foster care. Coverage of all youth, whether under private plans or under public programs such as Medicaid, is essential to a coherent system of health insurance for hundreds of thousands of youths as they mature into adulthood in a difficult economy where jobs are scarce. Striking down the mandatory coverage provision will upset the balance

that the ACA created in order for its other provisions to be feasible.

B. The ACA ensures that all children have access to affordable preventive health care services and programs.

Under the ACA, children will now have access to the preventive health care that has been out of their reach in the past. Children are especially in need of preventive health care: research on Medicaid eligibility in early childhood reveals that access to early adequate medical care has positive future effects on health, potentially placing children on healthier life trajectories. Janet Currie et al., *Has Public Health Insurance for Older Children Reduced Disparities in Access to Care and Health Outcomes?,* 27 JOURNAL OF HEALTH ECONOMICS 1567 (2008).

1. The ACA increases the affordability and availability of preventive health care services for children and their families.

The ACA increases the availability and affordability of preventive health care services. 42 U.S.C. § 300gg-13. The ACA requires health insurance providers to provide certain types of preventive care and forbids them from placing any cost-sharing requirements on the care on the following services:

> (1) evidence-based items or services that have in effect a rating of "A" or "B" in

> the current recommendations of the United States Preventive Services Task Force;
>
> (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
>
> (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
>
> (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

Id. The ACA specifically protects children by requiring – at no additional cost to the family – three categories of preventive care: (a) care for potential, expectant, and recent mothers, (b) recommended immunizations, and (c) care and screening of children.

a. The ACA protects children by making preventive health care for potential, expectant and recent mothers available and affordable.

Health care for mothers must extend from the prenatal to the postpartum period to sufficiently protect children's health. Paul H. Wise, *Transforming Preconceptional, Prenatal, and Interconceptional Care Into a Comprehensive Commitment to Women's Health*, 18 WOMEN'S HEALTH ISSUES S13 (2008). "The health of the mother during pregnancy impacts the child for life because the vast majority of a person's brain cells are born and formed in utero in the second and third trimester." Bruce Perry, *Childhood Experience and Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture*, 3 Brain and Mind 79, 82 (2002). Chemicals, such as alcohol and tobacco, transferred to the child in utero can change the ways in which neurons in the child's brain differentiate and ultimately function. *Id.* at 83. The health of the mother can alter the child's brain function for life.

Preventive health care covered by the ACA fills in the gaps and provides for screenings and services that span the preconception, prenatal, and postpartum periods. The ACA requires health insurance providers to cover health services and items that have a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force as well as additional screenings and services

specifically for women that are recommended by the comprehensive guidelines supported by the Health Resources and Services Administration. United States Preventive Services Task Force, USPTF A and B Recommendations (2010), *available at* http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm; Health Resources and Services Administration, Women's Preventive Services: Required Health Plan Coverage Guidelines (2011), *available at* http://www.hrsa.gov/womensguidelines. Many of the covered services, items, and screenings focus on preconception, prenatal, and postpartum preventive health care, ranging from contraceptive education to breastfeeding counseling.

Children benefit from their mothers' access to affordable preventive health care. When women's preventive health care is covered by health insurance, birth weights are healthier, and rates of disability and morbidity are lower. Jack Hadley, *Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income*, 60 MEDICAL CARE RESEARCH AND REVIEW 3S (2003); R.E. Behrman & A.S. Butler, *Preterm birth: Causes, consequences, and prevention*, National Academies Press (2007). Preventive health care for women – including tobacco-use, alcohol-use, and illicit drug-use counseling – is crucial in the preconception period because the woman only has a matter of months to ameliorate health issues during the prenatal period. Wise, *supra.* To best protect children,

preventive health care must be made available and affordable to women regardless of pregnancy status because approximately half of all pregnancies in the United States are unplanned. Lawrence B. Finer & Stanley K. Henshaw, *Disparities in rates of unintended pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 90 (2006). In making preventive health care more available and affordable to women regardless of pregnancy, ACA protects the health of future generations.

b. The ACA protects children by making the recommended immunizations available and affordable.

The ACA requires health insurance providers to make available, at no extra cost, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"). The CDC currently recommends routine vaccination to prevent 17 vaccine-preventable diseases that occur in infants, children, adolescents, or adults. Center for Disease Control and Prevention, General Recommendation on Immunization (Jan. 2011), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm?s_cid=rr6002a1_e.

Immunizations are one of the most cost-effective and successful preventive measures in health care.

Claire Hannan et al., *Maintaining the Vaccine Safety Net*, 124 PEDIATRICS S571 (2009). Yet, children in the United States still suffer and die from vaccine-preventable diseases. Vaccine-preventable meningitis took the life of college freshman Joseph Patrick Kepferle in 2000. In 2004, Nelyn Baker, an 18-day-old infant, died after contracting vaccine-preventable pertussis from his unvaccinated mother. A two-year-old child, who had not been vaccinated, died in New York in 2008 from vaccine-preventable Hib disease. *See* Immunize Action Coalition, Unprotected People Reports (2011), *available at* http://www.immunize.org/reports. Vaccines would have saved their lives.

Although vaccines are available and affordable to most children through private and public insurance or through the federal Vaccines For Children ("VFC") program, an estimated 11 percent of young children and 20 percent of adolescents fall outside of this coverage because they are underinsured and do not qualify for free VFC vaccines. Centers for Disease Control and Prevention, Report to Congress on Section 317 immunization program (2009), *available at* http://www.317coalition.org/documents/cdcreport11.pdf. Uninsured children are significantly less likely to receive appropriate and timely vaccinations. Philip J. Smith et al., *Associations Between Childhood Vaccination Coverage, Insurance Type, and Breaks in Health Insurance Coverage*, 6 PEDIATRICS 1972 (2006). Children with health insurance that requires cost-sharing for vaccinations are less likely to get vaccinated than children with health insurance that does

not require cost-sharing for vaccinations. Jonathan Gruber, *The Role of Consumer Copayments for Health Care: Lessons From the Rand Health Insurance Experiment and Beyond*, Kaiser Family Foundation (2006); G. Solanki & H.H. Schauffler, *Cost-sharing and the Utilization of Clinical Preventive Services*, 17 AM. J. PREV. MED. 127 (1999). Higher out-of-pocket costs translate to lower rates of vaccination. Megan C. Lindley et al., *National Vaccine Advisory Committee Report: Financing the Delivery of Vaccines to Children and Adolescents: Challenges to the Current System,* 124 PEDIATRICS S548 (2009). The ACA addresses this problem by mandating that every child be covered by health insurance and requiring the insurer to provide vaccinations at no additional cost.

c. The ACA makes care and screening of children's health available and affordable.

The ACA requires health insurance providers to make available, at no additional cost, evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"). The comprehensive guidelines supported by HRSA appear in two charts: the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care (2011), and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care (2011), *available at* http://brightfutures.aap.org/pdfs/AAPBrightFuturesPeriodicitySched101107.pdf; Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (2011), *available at* http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf.

The Bright Futures Recommendations provide for preventive health care measures that range from obesity screening to drug and alcohol abuse counseling. Notably, the recommendations include provisions for oral health risk assessment and appropriate follow-up care, a reform that would have saved Deamonte Driver's life. In 2007, at the age of 12, Deamonte Driver died after a tooth infection spread to his brain. Burton L. Edelstein & David A. Albert, *Columbia Commentary: The Boy Who Died From a Toothache* (2009), *available at* http://www.simplestepsdental.com/SS/ihtSS/r.==/st.126871/t.75944/pr.3.html. In 2007, there were twice as many children without dental coverage as there are children without health insurance. Charlotte Lewis et al., *Dental Insurance and its Impact on Preventive Dental Care Visits for U.S. Children*, 138 J. OF THE AM. DENTAL ASS'N 369 (2007). The ACA expands preventive health care so that oral health care is available and affordable to all children.

The Bright Futures Recommendations include many preventive health care services targeted at

adolescents. Few adolescents receive preventive health care visits: only about 38 percent of adolescents received a preventive visit in the last 12 months. Charles E. Irwin et al., *Preventive Care for Adolescents: Few Get Visits and Fewer Get Services*, 123 PEDIATRICS e565 (2009). Among those who received a visit, few were provided with treatment in line with the preventive health care in the comprehensive guidelines. *Id.* Making the preventive health care of the comprehensive guidelines affordable and available increases the number of children and adolescents who receive adequate preventive health care.

The screenings recommended by the Uniform Panel promote early detection and treatment of heritable disorders in newborns and children. Mary Ann Baily & Thomas H. Murray, *Ethics, Evidence, and Cost in Newborn Screening*, 38 HASTINGS CENTER REPORT 23 (2008). In 2000, two-year-old Ben Haygood died from a rare, inherited, undiagnosed medium chain acyl-coenzyme A dehydrogenase deficiency ("MCADD"). If Ben had been screened for MCADD at birth, his family would have known that Ben could not go without food for more than a couple of hours without getting violently ill, or possibly dying. A diagnosis would have saved his life. By requiring health insurance providers to cover newborn and child screening of heritable disorders, the ACA will save children's lives.

2. The ACA provides innovative programs to deliver health care to children in their own homes and communities and at their schools.

The ACA offers research-based preventive health care programs that are designed to benefit children. The ACA also designates millions of dollars to fund and improve these programs. These programs include (a) school-based health centers, (b) home visitation programs, and (c) obesity awareness initiatives. These provisions are vital to protecting the future health of our nation. If the mandate is struck down, these provisions which provide preventive care to promote healthy children and lower future expenditures will be lost.

a. The ACA provides school-based health centers.

The ACA provides an annual $50 million in grants between 2010 and 2013 to school-based health centers that serve children eligible for medical assistance. 42 U.S.C. §§ 280h-4 and 280h-5. School-based health centers increase access to health care for many of those who need it most, including underserved adolescents, a population long considered difficult to reach. Mandy A. Allison et al., *School-Based Health Centers: Improving Access and Quality of Care for Low-Income Adolescents*, 120 PEDIATRICS e887 (2007).

Studies have revealed that the availability of primary health care in a school-based setting leads to

increased use of primary care, reduced use of emergency rooms, and fewer hospitalizations. John Santelli et al., *School-Based Health Centers and Adolescent Use of Primary Care and Hospital Care*, 19 J. OF ADOLESCENT HEALTH 267 (1996). Such programs also result in a dramatic increase in adolescents seeking treatment for mental health problems and substance abuse. David W. Kaplan et al., *Managed Care and School-Based Health Centers*, 152 ARCH. PEDIATRICS & ADOLESCENT MEDICINE 25 (1998). Adolescents have also reported greater satisfaction with their health, more physical activity, and greater consumption of healthy foods as compared to non-users of school-based health programs. Miles A. McNall, *The Impact of School-Based Health Centers on the Health Outcomes of Middle School and High School Students*, 100 AM. J. PUBLIC HEALTH 1604 (2010).

Moreover, health and education are linked. Adolescents who experience worse health are substantially less likely to complete high school and transition to post-secondary education. Steven A. Haas et al., *Health and the Educational Attainment of Adolescents: Evidence from the NLSY97*, 49 J. HEALTH SOC. BEHAV. 178 (2008). In fact, the Centers for Disease Control has noted that "the academic success of America's youth is strongly linked with their health. . . . In turn, academic success is an excellent indicator for the overall well-being of youth, and is a primary predictor and determinant of adult health outcomes." Healthy Youth! Student Health and Academic Achievement, Centers for Disease Control

and Prevention (last visited Nov. 4, 2011), http://www.cdc.gov/healthyyouth/health_and_academics/index.htm. Given the proven efficacy of school-based health centers in reaching underserved populations, such programs ultimately do far more than simply treat the immediate primary care needs of youth.

In July 2011, $95 million in grants were provided to 278 school-based health center programs across the country, in the first series of awards under these provisions. *HHS Announces New Investment in School-Based Health Centers*, U.S. Department of Health & Human Services (2011), http://www.hhs.gov/news/press/2011press/07/20110714a.html. These grants will allow awardees, already serving some 790,000 patients, to serve an additional 440,000 patients. *Id.* The ACA provides for an additional $105 million toward such programs through 2013, allowing hundreds of thousands more to be served.

b. The ACA increases funding for home visitation programs.

The ACA provides $1.5 billion toward early childhood home visitation programs. 42 U.S.C. § 711. Individual states are asked to identify communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child

maltreatment. The provisions incentivize states to invest in evidence-based early childhood home visitation initiatives.

Home visitation has been recognized for its potential to foster early child development and competent parenting, as well as to reduce risk for child abuse and neglect and other poor outcomes for vulnerable families. Lenette Azzi-Lessing, *Home Visitation Programs: Critical Issues and Future Directions*, 25 EARLY CHILDHOOD RESEARCH QUARTERLY 387 (2011). However, it has also been widely recognized that more rigorous research into all phases of home visitation research is needed. Denise K. Thompson, *The Patient Protection and Affordable Care Act of 2010 (PL 111-148): An Analysis of Maternal-Child Health Home Visitation*, 12 POLICY POLITICS & NURSING PRACTICE 175 (Oct. 2011).

Under the ACA, 75 percent of total funding will go toward well-designed, research-based, and rigorously evaluated programs. 42 U.S.C. § 711(d)(3)(A)(i)(I). The remaining 25 percent will go toward new and promising approaches yet to be evaluated. 42 U.S.C. § 711(d)(3)(A)(ii); *see also* 42 U.S.C. § 711(d)(3)(A)(i)(II). All funded programs must establish quantifiable three- and five-year benchmarks for improvements in fields such as maternal and newborn health, prevention of injuries or child abuse, emergency department visits, school readiness, crime or domestic violence, and family economic self-sufficiency. Failure to do so could ultimately result in the revocation of the grant.

Thus, the ACA helps to jumpstart promising initiatives in maternal and early childhood health, the benefits of which may be long-term and substantial. The repeal of such provisions would be to the detriment of state-based early childhood home visitation programs across the country and destroy many opportunities for further research.

c. The ACA provides increased funding for and awareness of childhood obesity initiatives.

Childhood obesity is "epidemic" in the United States. Thomas R. Frieden et al., *Reducing Childhood Obesity Through Policy Change: Acting Now to Prevent Obesity*, 29 HEALTH AFF. 357 (2010). The consequences of this epidemic include earlier puberty and menarche in girls, type 2 diabetes and increased incidence of metabolic syndrome in youth and adults, obesity in adulthood, as well as cardiovascular disease and several cancers in adults. Frank M. Biro & Michelle Wien, *Childhood Obesity and Adult Morbidities*, 91 AM. J. CLIN. NUTR. 1499S (2010). Policy interventions, such as the obesity-related measures included in the ACA that make healthy dietary and activity choices easier, are needed to push comprehensive change in attitudes toward childhood obesity. Frieden, *supra* at 360. Such provisions in the ACA make sure that we act now, before the epidemic of childhood obesity "become[s] increasingly difficult to address." *Id.*

Several provisions in the ACA are designed to provide obesity-related services to the population at large. For example, the ACA provides education and outreach regarding preventive benefits. 42 U.S.C. § 300u-12. Such provisions include raising awareness of obesity screening and counseling for children and adults enrolled in Medicaid. 42 U.S.C. § 300u-12(i).

The ACA provides $25 million in funding for the Childhood Obesity Demonstration Project, an initiative to address childhood obesity. 42 U.S.C. § 1320b-9a(e)(8). Over the period of fiscal years 2010 to 2014, the Secretary of Health and Human Services may award grants to develop a "comprehensive and systematic model for reducing childhood obesity." 42 U.S.C. § 1320b-9a(e)(1). These grants will help schools, recreation facilities, daycare facilities, and other community organizations to promote nutrition and healthy eating behaviors, physical activity, and other after-school and weekend activities to reduce obesity. 42 U.S.C. §§ 1320b-9a(e)(3)(A)(i)-(iii). They will also help educators, health professionals, parents, and others promote these healthy habits. 42 U.S.C. §§ 1320b-9a(e)(3)(B)-(D).

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CONCLUSION

This Court should consider the special importance of the ACA to families and children who are already receiving the benefits of enhanced access to health insurance coverage and quality health care, defer to the policy judgments of elected officials and uphold the constitutionality of the ACA.

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