IN THE SUPREME COURT OF OHIO

THE STATE *ex rel.* CLEVELAND RIGHT TO LIFE, INC., et al.	:	Case No. 2013-1668
v.	:	Original Action in Mandamus
STATE OF OHIO CONTROLLING BOARD, et al.	:	

BRIEF OF AMICUS CURIAE AARP IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Regulations

Other Authorities

Miscellaneous

Miscellaneous

Miscellaneous

STATEMENT OF INTEREST

AARP is a nonprofit, nonpartisan organization, with a membership, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as health care, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

Since its founding in 1958, AARP has advocated for affordable, accessible health care, as well as improved quality of care and controlled health care costs. In response to the growing number of older people who forgo health care services and face financial ruin due to the unaffordability and unavailability of insurance and other health care costs, AARP sought legislative solutions that would, among other objectives, reduce the increasing rate of health care costs and make health insurance affordable for low-income older people. While Congress debated health reform legislation, AARP's advocacy focused on guaranteeing access to affordable coverage for Americans ages 50 to 64, both to address the problems of those who faced unaffordable insurance costs in the individual market, and to expand Medicaid eligibility as an efficient and effective way to assure low-income adults quality coverage and access to care.

Following the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, AARP engaged in national and statewide efforts to promote the ACA's features and benefits. Over the past several years, AARP Ohio urged the Ohio legislature and Governor to accept federal funds for the expansion of Medicaid eligibility in Ohio. AARP Ohio recently engaged a team of volunteers across the state to educate the public about the ACA and its benefits. Consistent with its advocacy on the national and state levels, AARP's interest in this matter is to ensure that low-income older Ohioans obtain affordable health insurance through the expansion of Medicaid eligibility.

INTRODUCTION

Relators' request that this Court invalidate the vote of the Controlling Board, which allows Ohio to accept federal funds to expand Medicaid eligibility to low-income Ohioans, is against the public interest and should be denied. The requested relief will harm low-income Ohioans and will have a deleterious effect on representative state government.

Uninsured low-income adults ages 50 to 64 are some of the most vulnerable potential beneficiaries of Medicaid expansion. They have a higher prevalence of chronic health conditions and increased need for health care as they age. At the same time, many such adults are uninsured and, as a result, have very limited access to needed health care. Low-income pre-Medicare adults ages 50 to 64[1] are unable to afford private health insurance, and often do not qualify for Medicaid or other public coverage. They are not are not eligible for Medicare, either because they are not disabled or because they have not reached the age of eligibility. Expanding Medicaid eligibility will provide affordable health insurance and improve health outcomes for approximately 114,000 low-income Ohioans ages 50 to 64.

The General Assembly did not prohibit the expansion of Medicaid eligibility in the prevailing appropriations act and the Controlling Board acted consistent with the intent expressed therein. If the requested relief is granted, the Court will substitute the legislature's intent as expressed in the prevailing appropriations act with that of a few discontented legislators, who do not speak for the General Assembly. This would abrogate the Governor's constitutional veto power and have a deleterious effect on the health of State representative government.

[1] The term "pre-Medicare adults" refers to those ages 50 to 64.

STATEMENT OF FACTS

Amicus agrees with the statement of facts as expressed in Respondents' brief and, therefore, omits such a statement pursuant to S.Ct.Prac.R. 16.03(B)(2).

ARGUMENT

Proposition of Law:

The Controlling Board was within its statutory and Constitutional authority in voting to appropriate federal funds for expanded Medicaid eligibility, improving the lives and health outcomes of thousands of pre-Medicare low-income Ohioans, and consistent with the General Assembly's intent as expressed in the prevailing appropriations act.

I. Vulnerable Low-Income Pre-Medicare Adults Need Medicaid Coverage to Protect Their Lives and Improve Their Health Outcomes.

Granting a writ of mandamus "rests in the sound discretion of the court." *State ex rel. Pressley v. Indus. Comm'n of Ohio*, 11 Ohio St. 2d 141, 153 (1967) (quoting *Perkins v. Quaker City*, 165 Ohio St. 120 (1956)). In exercising its discretion, the court may consider all relevant facts and circumstances, including "the interests of third persons ... [and] public policy and the public's interest" in the matter before the court. *Hunter v. Britten*, 180 Ohio App. 3d 755, 2009-Ohio-663, 907 N.E.2d 360, ¶ 59 (6th Dist.) (citing *Pressley*, 11 Ohio St.2d at 163). As the court considered the public's interest in *Hunter* and considered the general public policy that favors "allowing citizens a voice in the shaping of their community," *Hunter*, at 771, so too should this Court consider the voices of the hundreds of thousands of Ohioans who need Medicaid coverage to protect their lives and improve their health outcomes.[2]

[2] The Court should also consider the public's interest in realizing the broader benefits of Medicaid expansion for the health care system as a whole, as other Amici in support of Respondents explain in more detail.

A. Many Low-Income Pre-Medicare Adults Lack Health Insurance Because They Do Not Have Employer-Based Insurance, Cannot Afford Private Insurance, or Do Not Qualify for Publicly-Funded Insurance Programs.

The vast majority of the uninsured do not have health insurance because available employer-sponsored insurance is unaffordable, they do not have access to employer-sponsored insurance, insurance in the private individual market is unaffordable, or they do not qualify for publicly-funded insurance programs. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population*, (2013).[3] The nine million pre-Medicare adults in the U.S who were uninsured in 2012 also faced these barriers. AARP Pub. Policy Inst., *Analysis of March 2013 Current Populations Survey, U.S. Census Bureau.*[4]

For many older workers, employer-sponsored insurance is not available or is unaffordable. In 2012, an estimated eleven million working pre-Medicare adults did not have employer-sponsored insurance. Of these, over half did not have health insurance coverage from an alternative source. *Id.* Additionally, employer-sponsored insurance is not available to many pre-Medicare adults because they are unemployed or out of the workforce.

Sixty five percent of the 114,000 pre-Medicare adults in Ohio who are uninsured and live at or below 138% of poverty are either unemployed or out of the work force. AARP Pub. Policy Inst., *Analysis of Urban Institute Estimates Based on American Community Survey Records, 2008-2010* [hereinafter *AARP ACS Analysis*]. Lack of labor force attachment may be driven, in part, by the recent economic recession, during which the unemployment rate and the rate of those without health insurance rose for people ages 45 to 64. Lynda Flowers & Matthew Buettgens,

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[3] *Available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf.

[4] Analyzing U.S. Census Bureau, *Current Population Survey, 2013 Annual Social and Economic Supplement* (2013), *available at* http://www.census.gov/prod/techdoc/cps/cpsmar13.pdf.

After the Supreme Court Decision: The Implications of Expanding Medicaid for Uninsured Low-Income Midlife Adults, AARP Pub. Policy Inst., Insight on the Issues, Jan. 2013, at 2. Pre-Medicare adults feel the harmful effects of uninsurance related to lack of employment more acutely than their younger counterparts because, on average, they remain unemployed longer than younger unemployed adults. For example, as of September 2013, pre-Medicare adults remained unemployed for 21 weeks longer than their younger counterparts. Sara E. Rix, AARP Pub. Policy Inst., *The Employment Situation, September 2013: Almost No Good News for the Older Workforce*, Fact Sheet 293, (2013).[5]

Many pre-Medicare adults cannot afford insurance policies on the private market. In 2007, 61% of those adults who tried to purchase health insurance on the private market found it unaffordable. *See* Sara R. Collins, et al., The Commonwealth Fund, *Realizing Health Reform's Potential: Adults Ages 50-64 and the Affordable Care Act of 2010*, Dec. 2010.[6] The high cost of health insurance for older adults has historically been linked to insurance underwriting policies that allowed insurers to deny coverage, charge high deductibles, and offer very limited policies to people with pre-existing conditions and to charge high premiums based on age alone. Elizabeth Abbott, et al., *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Lawmakers and Regulators*, Aug. 2012 [hereinafter *Implementing ACA's Reforms*].[7] Though ACA reforms prohibit some of these practices, under the ACA insurers can

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[5] AARP's analysis is based on statistics from the U.S. Dep't of Labor, Bureau of Labor Statistics, *The Employment Situation—September 2013*, USDL-13-2035 (2013). Due to the government shutdown, the September employment figures were released on October 22.

[6] *Available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Dec/1460_Collins_adults_50_to_64_ACA_reform_brief_v2.pdf.

[7] *Available at* http://www.naic.org/documents/committees_conliaison_1208_consumer_recs_aca.pdf.

still set premiums based on older age alone that are three times greater than premiums for younger people. *See* 42 U.S.C. § 300gg(a)(1)(A)(iii). This differential can still be prohibitively expensive to low-income older adults. *See Implementing ACA's Reforms*, at 14 (recommending that states adopt more protective age rating restrictions to protect older adults from bring priced out of the individual private insurance market). Additionally, insurers will still have access to information about individuals (such as age, health status, and past claims data) before they enroll in a plan, allowing insurers to steer people away from particular plans that may be more affordable. *Id.* at 11. Without Medicaid expansion, low-income pre-Medicare adults shopping for health insurance in the private market will still face higher premiums and higher out-of pocket costs than their younger counterparts—higher costs that make insurance unaffordable for those living below 138% of poverty.

Many adults ages 50 to 64 are not eligible for Medicaid or Medicare. Before the ACA authorized funding for Medicaid expansion, only 24 states and the District of Columbia provided Medicaid for adults without dependent children no matter how low their income. Ohio was not one of those states. *See* Kaiser Family Found., *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013*, Jan. 2013.[8] Unless an applicant qualifies for Medicare based on the receipt of Social Security disability benefits or end-stage renal disease, Medicare will not cover them until they reach age 65. *See* 42 U.S.C. § 1395(c) (2012). In Ohio, only 16% of Medicare beneficiaries qualify based on disability. *See* Kaiser Family Found., *Distribution of Medicare*

[8] *Available at* http://www.kff.org/medicaid/ report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/.

Beneficiaries by Eligibility Category (2009).[9] Medicaid expansion offers Ohio the opportunity to level the playing field for all low-income people in the state by providing access to insurance coverage to all low-income residents, especially pre-Medicare adults, who may need it the most.

B. Uninsured Adults Are Less Likely to Receive Preventive Services and Medical Treatments and Will Experience Worse Health Outcomes and Higher Mortality Rates Than Those Who Are Insured.

Adults without health insurance are less likely to receive appropriate preventive services and medical treatments. Nationally, uninsured pre-Medicare adults are about three times less likely to be up-to-date with clinical preventive services than those who are insured. *See* Megan Multack, *State Preventive Care Ranking For Midlife Adults*, AARP Pub. Policy Inst., Aug. 2013.[10] These disparities are even greater in Ohio, where uninsured older Ohioans are about four times less likely to be up-to-date with clinical preventive services than those who are insured. *Id.*

Uninsured adults who do not receive preventive services and treatments are more likely to experience poor health outcomes and die sooner than their insured counterparts. A review of studies comparing health outcomes of insured and uninsured adults 18 to 64 years of age revealed that uninsured adults: (1) are less likely to be aware of heart disease and its risk factors and less likely to have these conditions treated or well-controlled; (2) are more likely to have their cancers diagnosed and treated in their advanced stages resulting in poorer health outcomes or death; and (3) have higher mortality rates than their insured counterparts. Inst. of Med., *America's Uninsured Crisis: Consequences for Health and Health Care*, 72-83 (2009). Additionally, the Institute of Medicine (IOM) found that uninsured individuals with chronic illnesses such as hypertension, diabetes, cancer, and heart disease suffer worse health outcomes due to delayed diagnoses and delayed treatment, and thus would most likely benefit from health

[9] *Available at* http://kff.org/medicare/state-indicator/beneficiaries-by-eligibility-category/.

[10] http://www.aarp.org/State-Preventive-Care-Rankings/ (last visited Nov. 15, 2013).

insurance. *Id.* at 74-80. Finally, the IOM found that when previously uninsured older adults gain Medicare coverage at age 65, they experience improved health outcomes and a decreased risk of dying when hospitalized for serious conditions. *Id.* at 72. These findings suggest that adults ages 50 to 64 have significant unmet health needs before they become old enough to qualify for Medicare, and that they would benefit from access to Medicaid during their middle years.

The improved outcomes that older adults experience when they enroll in Medicare are related to increased access to prescription drugs and other medical treatments to control their illnesses, *id.* at 77, and they come at higher cost to the Medicare system. *See* J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 347 New Eng. J. Med. 143, 151 (2007).[11] If low-income pre-Medicare adults have preventive services and medical treatments earlier, the cost of drugs and medical treatments will be substantially less when they qualify for Medicare because their conditions would be diagnosed earlier, would be at less advanced stages, and/or would be better controlled. *See The Instability of Health Coverage in America: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Cong. 50 (2008) (statement of Dr. John Z. Ayanian). For example, one study found that if adults younger than 65 receive screening for colorectal cancer, Medicare could realize between $7.7 and $21.7 billion in savings related to their cancer treatment. *See* Nat'l Colorectal Cancer Roundtable, *Increasing Colorectal Cancer Screening – Saving Lives and Saving Dollars: Screening 50 to 64 year olds Reduces Cancer Costs to Medicare*, 2-3 (2008).[12]

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[11] *Available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa067712.

[12] *Available at* http://nccrt.org/about/policy-action/savings-to-medicare/.

C. Pre-Medicare Adults Suffer from Chronic Health Conditions at Higher Rates Than Younger Adults, Resulting in Worse Health Outcomes for the Older Uninsured and Increased Cost.

As people age, they are more likely to experience chronic health conditions—the very conditions that result in worse health outcomes and increased mortality for the uninsured. A recent analysis by the U.S. Department of Health and Human Services shows that 48 to 86% of people ages 55 to 64 have a pre-existing health condition, while only 9 to 35% of adults ages 18 to 24 had a pre-existing health condition. U.S. Dep't of Health & Human Servs., *At Risk: Pre-Existing Health Conditions Could Affect 1 in 2 Americans*, (2011).[13] Many of these pre-existing health conditions are chronic—long-lasting conditions that can be controlled but not cured. Examples of chronic conditions are heart disease, hypertension, cancer, diabetes, and arthritis.

The prevalence of multiple chronic conditions is greater in adults ages 45 to 64 than in younger adults, and has increased significantly for the older population between 2001 and 2010. Brian W. Ward & Jeannine S. Schiller, *Prevalence of Multiple Chronic Conditions among US Adults: Estimates from the National Health Interview Survey, 2010*, 10 Preventing Chronic Disease 1, 4-5 (2013).[14] The most common triad present in adults ages 45 to 64 with multiple chronic conditions ages 45 to 64 is arthritis, diabetes, and hypertension. *Id.* Additionally, adults ages 45 to 64 suffer from heart disease at a rate three times higher than the rate for adults ages 18 to 44. Jeannine S. Schiller J.S. et al., *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010*, 10 Vital Health Stat., 16, 19 (2012).

The Centers for Disease Control and Prevention estimate that chronic conditions are the leading cause of death and disability and that treating such conditions accounts for 75% of health

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[13] *Availabe at* http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml.

[14] *Available at* http://dx.doi.org/10.5888/pcd10.120203.

care spending. *Chronic Disease Prevention and Health Promotion*, Centers for Disease Control and Prevention.[15] This tremendous toll on human life and on health care resources can be reduced because these conditions are some of the most preventable and can be effectively controlled. *See What is Chronic Disease?*, The Center for Managing Chronic Disease.[16] In order to reduce this toll, however, people must have access to preventive services for early awareness of risk factors, diagnosis, and treatment. As explained above, being uninsured is a significant barrier to seeking such services. Expanding Medicaid eligibility will reduce this barrier.

D. Expanded Medicaid Eligibility Will Provide Affordable Health Insurance to Low-Income Uninsured Pre-Medicare Adults.

Under the ACA, states receive federal funds to expand their Medicaid eligibility criteria to certain persons living at or below 138% of poverty, including to adults without dependent children. Nationally, millions of pre-Medicare adults would qualify for Medicaid under the expanded eligibility criteria. In Ohio, about 114,000 uninsured low-income adults ages 50 to 64 would qualify for Medicaid: 83,400 have incomes below 100% of poverty and 30,600 have incomes between 100% and 138% of poverty. *AARP ACS Analysis*. Because the Medicaid program only requires individuals to pay nominal cost-sharing, and caps such cost-sharing at 5% of income, expanding Medicaid will ensure that pre-Medicare adults will access the most affordable coverage available.

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[15] http://cdc.gov/chornicdisease/ (last visited Nov. 15, 2013).

[16] http://cmcd.sph.umich.edu/what-is-chronic-disease.html (last visited Nov. 15, 2013).

E. Without Medicaid Coverage, Health Insurance Will Remain Unaffordable to Many Low-Income Pre-Medicare Adults.

Notwithstanding ACA reforms designed to make health insurance more affordable, without Medicaid expansion, health insurance will remain unaffordable for some of the most vulnerable citizens. Under the ACA, tax credits for the purchase of insurance in the individual marketplace to help individuals pay their premiums are only available to those whose income is between 100 and 400% of poverty. 26 U.S.C. § 36B(b)(3)(A)(i) (2012). The law does not provide this assistance to people below 100% of poverty. There are millions of Americans and thousands of Ohioans who are uninsured and live below 100% of poverty and will not qualify for premium subsidies in the health insurance marketplace. Without Medicaid expansion, an estimated 83,400 low-income uninsured Ohioans ages 50 to 64 would not qualify for these federal subsidies. *AARP ACS Analysis.*

Even those with incomes between 100 and 138% of poverty who qualify for subsidies for private insurance premiums may find that insurance is still unaffordable because under the ACA individuals are expected to contribute a percent of their income to premiums. The expected contribution rises with income; individuals below 133% of poverty are expected to contribute 2% of the income to premiums, at 138% of poverty the share is 3% and the share rises to 9.5% by 300% of poverty. 26 U.S.C. § 36B(b)(3)(A)(i). Additionally, individuals with incomes between 100% and 250% of poverty are eligible for subsidies to assist with out-of-pocket costs. 42 U.S.C. § 18071(c)(2) (2012). Below 150% of poverty, cost-sharing subsidies would reduce an individual's share of out-of-pocket costs to 6%. But even with premium and cost-sharing subsidies, some families may find private insurance difficult to afford. Affordability as defined by the ACA may be different from unaffordability as dictated by a family's actual needs.

While official poverty levels are used to measure how many Americans live in economic deprivation, they do not measure how much income a family needs to live securely, but modestly. *See* Elise Gould, et al., *What Families Need to Get By: The 2013 Update of EPI's Family Budget Calculator*, 368 Econ. Pol'y Inst. 1, 2 (2013).[17] For example, under the ACA a single parent with two children with an annual income of $25,975 (or 133% of poverty) would be expected to pay 3% of the annual premium cost, or $779 per year (approximately $65 per month). *See* Subsidy Calculator, Kaiser Family Found.[18] According to the Economic Policy Institute's Family Budget Calculator, a family of the same size living in Cincinnati-Middleton, Ohio needs $55,885 per year in order to provide for necessities such as housing, food, child care, transportation, health care, other necessities, and taxes. *See* Family Budget Calculator, Econ. Policy Inst.[19] This estimated family budget is 286% of the federal poverty level. Even if the cost of health care is excluded from this family's budget, they would still need an annual income of $40,224, or 206% of the poverty level, to meet their needs. *Id.* This suggests that even if low-income families can qualify for subsidies in the private health insurance market they will have real challenges and tradeoffs in paying for health care. The economic reality is that, absent Medicaid expansion, low-income adults will not have any new affordable health insurance options.

F. Expanded Medicaid Eligibility Will Help Reduce Racial and Ethnic Disparities in Health Insurance Coverage.

In addition to providing life-saving health insurance for low-income pre-Medicare adults, Medicaid expansion will help reduce existing racial and ethnic disparities in insurance coverage.

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[17] *Available at* http://www.epi.org/publication/ib368-basic-family-budgets/.

[18] http://kff.org/interactive/subsidy-calculator/ (last visited Nov. 15, 2013).

[19] http://www.epi.org/resources/budget (last visited Nov. 18, 2013).

Minority pre-Medicare adults are uninsured at higher rates than non-minority pre-Medicare adults. African Americans are 8% less likely and Hispanics are 19% less likely to be insured than whites. Lisa Clemans-Cope et al., *The Affordable Care Act's Coverage Expansions Will Reduce Differences In Uninsurance Rates By Race And Ethnicity*, 31 Health Affairs 920, 923 (2012) (citing Urban Institute analysis, *Health Insurance Policy Simulation Model*, 2011). Medicaid expansion could help reduce these racial and ethnic disparities. The Urban Institute projects that, if the ACA is implemented, the rate of uninsurance will drop by 11.8% for African Americans and 12.2% for Hispanics. *Id.* Though these reductions may be influenced by various factors, the majority of the projected decreases is attributable to the expansion of public insurance programs, including Medicaid. *Id.*

Not only is the requested relief contrary to the public's interest and harmful to low-income Ohioans, but, as explained below, it is also without legal support and would have a deleterious effect on representative government in Ohio.

II. The Controlling Board's Vote Was Within its Statutory and Constitutional Authority; Invalidating the Vote Would Abrogate the Governor's Veto and Have a Deleterious Effect on State Representative Government.

AARP hereby incorporates by reference the Argument of Amici Curiae Ohio Provider Resource Association, Ohio Council of Behavioral Health & Family Services Providers, National Alliance on Mental Illness, the Ohio Association of County Behavioral Health Authorities, and Advocates for Ohio's Future. As explained therein, the Controlling Board is authorized to approve the expenditure of federal funds; and Relators concede that the General Assembly's delegation of this authority is Constitutional.

The only issue is whether the Controlling Board acted within the Constitutional confines of that delegated authority by taking "no action which does not carry out the legislative intent of

the general assembly regarding program goals and levels of support as expressed in the prevailing appropriation acts of the general assembly." Ohio Rev. Code Ann. § 127.17 (Lexis Nexis 2013) (emphasis added). Relators erroneously argue that legislative intent is found in language that was vetoed by the Governor and is not part of the prevailing appropriations act. This argument has no legal support and, paradoxically, undermines the separation of powers and system of checks and balances that Relators ostensibly seek to preserve. *See* V. Compl. ¶ 108.

This Court has recognized that the Governor's veto is part of those checks and balances, part of the legislative process, and a limit on the Controlling Board's authority. In *State ex rel. Public Utils. Comm'n v. Controlling Bd. of Ohio,* 130 Ohio St. 127 (1935), the Governor vetoed certain appropriations for the Public Utilities Commission, and the Commission petitioned the Controlling Board to give it access to funds appropriated for other purposes in order to fund the vetoed items. When the Controlling Board refused to grant the request, the Commission sued. This Court held that the Controlling Board was correct not to transfer the funds because it "would result in thwarting or circumventing the veto power of the Governor." *Id.* at 132. If the writ of mandamus is granted, it would signal that any legislator who is unhappy with the Governor's exercise of his veto power and was unable or unwilling to override that veto through the legislative process,[20] may circumvent the veto by petitioning this Court. The requested relief would have a deleterious effect on state representative government and should, therefore, be denied.

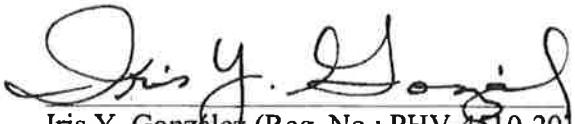
[20] Legislators may have considered the political risk of opposing a Medicaid expansion that is supported by 63% of Ohioans. *See* Ohio Health Issues Poll, 2013, *available at* https://www.interactforhealth.org/upl/Ohioans_views_about_Medicaid_expansion.pdf.

CONCLUSION

The Court should consider the effects of invalidating the decision to fund expanded Medicaid eligibility on the thousands of low-income Ohioans who are the direct beneficiaries of the expansion. Absent Medicaid expansion, health insurance would remain unaffordable to thousands of low-income pre-Medicare Ohioans who would continue to suffer adverse health consequences as a result. The Controlling Board acted within its authority to accept federal funding of expanded Medicaid eligibility, as the prevailing appropriations act contained no expression of the General Assembly's intent to prohibit such an expansion, but rather was silent on the issue. Relators' use of a mandamus action is a thinly-veiled attempt to achieve something they could not and did not accomplish through the constitutionally and statutorily-defined legislative process. For these reasons, as well as the reasons articulated by Respondents and other Amici in support of Respondents, this Court should deny the writ.

Dated: November 25, 2013.

Respectfully submitted,



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I hereby certify that on this 25th day of November, 2013, the foregoing Amicus Brief was served via first class mail and e-mail upon all parties listed below as follows:

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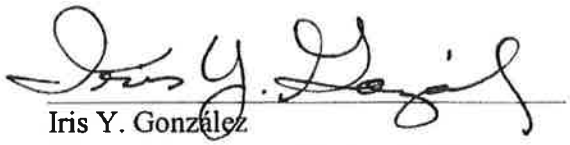

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