UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART et al., *Plaintiffs*, v. ALEX M. AZAR II et al., *Defendants*.	)	Civil Action No. 1:18-cv-152(JEB) Hon. James E. Boasberg

BRIEF FOR THE AMERICAN ACADEMY OF PEDIATRICS, THE AMERICAN COLLEGE OF PHYSICIANS, THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, MARCH OF DIMES, AND THE NATIONAL ALLIANCE ON MENTAL ILLNESS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS

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January 24, 2019

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STATEMENT OF INTEREST

The American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Medical Association (AMA), the American Psychiatric Association (APA), the Catholic Health Association of the United States (CHA), March of Dimes, and the National Alliance on Mental Illness (NAMI) respectfully submit this brief as *amici curiae* in support of Plaintiffs.[1]

AAP is an organization of 67,000 pediatricians committed to protecting the well-being of America's children, including by engaging in broad and continuous efforts to prevent harm to the health of infants, children, adolescents, and young adults caused by a lack of access to health coverage and care.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

AMA is the largest professional association of physicians, residents, and medical students in the United States. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all areas of specialization and in all 50 states, including Kentucky, and the District of Columbia.

APA, with more than 37,800 members, is the nation's largest organization of physicians who specialize in psychiatry. Through research, education, and advocacy, its members work to

[1] No party or counsel for a party authored the brief in whole or in part, and no party, counsel for a party, or person other than *amici curiae*, their members, or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

ensure effective and accessible treatment for all persons with mental health and/or substance use disorders.

CHA is the national leadership organization for the Catholic health ministry. This ministry comprises more than 650 hospitals and 1,600 long-term care and other facilities in all 50 states and the District of Columbia. CHA advances the Catholic health ministry's commitment to a just, compassionate health care system that protects life.

March of Dimes is a nonprofit organization that leads the fight for the health of all mothers and babies. Ensuring that pregnant women and children have access to timely, affordable, and high-quality health care is essential to achieving its goals.

NAMI is the nation's largest grassroots organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support, and research, and is steadfast in its commitment to raising awareness and building a community of hope for individuals living with mental illness across the lifespan.

Amici and their members are deeply concerned about Kentucky HEALTH—and programs like Kentucky HEALTH—that threaten low-income Medicaid beneficiaries with the loss of their health benefits in the name of encouraging them to seek employment. Plaintiffs explain why the Department of Health and Human Services' (HHS's) approval of Kentucky HEALTH is unlawful. Pls.' Mot. for Summ. J., at 11-43 [Dkt. No. 91-1]. *Amici* write to further explain that Kentucky HEALTH will not achieve its stated goals. Far from yielding better health outcomes and reducing dependence on government programs, Kentucky HEALTH will harm the health of Kentucky Medicaid beneficiaries and increase health care-provider and government expenditures in the long term. The Court should vacate HHS's approval of Kentucky HEALTH.

SUMMARY OF ARGUMENT

In 2014, Kentucky expanded Medicaid eligibility to over 454,000 newly eligible beneficiaries. That expansion dramatically improved health outcomes. Hundreds of thousands of Kentuckians were able to access a full range of health care services for the first time. For new beneficiaries, there was a substantial rise in primary-care visits, specialist treatment, mental-health screenings, preventive screenings, and prescription-drug access—all with a drop in costly and inefficient emergency-room visits. Not surprisingly, new Medicaid recipients reported that their coverage allowed them to substantially improve their health.

Despite these gains, Kentucky decided to change course. With HHS's approval, the Commonwealth introduced Kentucky HEALTH, a program that will take Medicaid coverage away from certain beneficiaries if they do not satisfy work requirements—or, as the Commonwealth calls them, "community engagement" requirements. This Court has once invalidated HHS's approval of Kentucky HEALTH because HHS failed to consider whether the program "would help provide health coverage for Medicaid beneficiaries." *Stewart v. Azar*, 313 F. Supp. 3d 237, 262 (D.D.C. 2018) (emphasis omitted). After a second round of public comments, HHS re-approved Kentucky HEALTH, but this second iteration is nearly identical to the first. As before, the plan's proponents assert that work requirements will lift beneficiaries out of unemployment, improve health outcomes, and strengthen the social safety net.

They are wrong. *First*, conditioning eligibility for coverage on employment will lead to mass disenrollment and health outcomes that dramatically worsen over time. By the Commonwealth's own estimates, this plan will lead to 1.14 million lost coverage months—the equivalent to nearly 100,000 people losing coverage for a year. That is because most of Kentucky's unemployed beneficiaries are not merely jobless; they are unable to work. Even

those who are actively looking for employment face serious issues in finding and keeping a job that will only be exacerbated by taking away their health care. And many Medicaid beneficiaries who have jobs do not work according to consistent schedules—making it difficult to meet Kentucky HEALTH's one-size-fits-all work requirements. HHS and Kentucky do not explain how these often-insurmountable barriers to entering the workforce and remaining employed will go away just because the Commonwealth has made employment a condition of eligibility for Medicaid coverage. To the contrary, many unemployed and underemployed beneficiaries will simply lose coverage. All will face higher barriers between them and the medical treatment they need. And some could get sicker and even die prematurely.

Second, Kentucky HEALTH imposes new burdens and penalties on beneficiaries that jeopardize the coverage of even the gainfully employed. Kentucky HEALTH requires beneficiaries to report their work status monthly. Any reporting mistake could trigger disenrollment. Kentucky's Medicaid program requires beneficiaries to shoulder premiums, report any change affecting eligibility, and submit documentation for annual eligibility re-determinations. Under Kentucky HEALTH, the failure to check these boxes can lock beneficiaries out of coverage for up to six months, creating a steady churn of people losing coverage only to re-gain it months later, possibly after they have already become sick. Kentucky HEALTH also terminates non-emergency medical transportation benefits for many beneficiaries, effectively blocking them from using their benefits. Intermittent, unreliable coverage is little better than being permanently uninsured.

Third, Kentucky HEALTH financially burdens beneficiaries, providers, and the Commonwealth. Losing benefits exposes former beneficiaries to the risk of medical bills they cannot afford and, in some cases, the threat of bankruptcy. Without a reliably insured patient

population, rural providers could be forced to shut their doors. And Kentucky HEALTH will increase certain government expenses, largely offsetting the fiscal benefits of mass disenrollment. The plan will create new administrative expenses, and increase program costs when healthy beneficiaries lose their coverage only to re-enroll when their health has worsened and their conditions are more costly to treat.

For a second time, HHS's approval of Kentucky HEALTH ignores all of this evidence. HHS's explanation for granting the waiver therefore "runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). It should be set aside.

ARGUMENT

I. BY CAUSING THOUSANDS TO DISENROLL FROM MEDICAID, THE WORK REQUIREMENTS WILL LEAD TO FAR WORSE HEALTH OUTCOMES.

Kentucky's new work requirements will not "improve the health of Medicaid beneficiaries," as HHS asserts. AR 6723. It will deprive thousands of the neediest beneficiaries of their coverage and trigger an avalanche of negative health results. Many of the disenrolled will become sicker, and some could die prematurely.

A. Kentucky HEALTH Will Strip Thousands Of Their Health Coverage.

The Commonwealth itself projects that Kentucky HEALTH will lead to 1.14 *million* lost coverage months. AR 5427. That is "the equivalent of nearly 100,000 people losing coverage for a full year, or, more likely, well over 100,000 people experiencing [short-term] gaps in coverage." Judith Solomon, Ctr. on Budget and Policy Priorities, Kentucky Waiver Will Harm Medicaid Beneficiaries 2 (Jan. 16, 2018), *available at* https://tinyurl.com/ybbs26dq ("*Waiver Will Harm*"). Nearly 165,000 Kentucky Medicaid beneficiaries are not working and are not exempt from the work requirements. *See* AR 16830. Another 55,000 work too inconsistently to

enjoy guaranteed coverage for the entire year under the new plan. *See* AR 13200-13201. HHS and Kentucky contend that threatening to eliminate Medicaid coverage will "encourage[]" these beneficiaries to "attain or retain financial independence." AR 6724.

HHS and Kentucky apparently assume that 165,000 non-working, non-exempt Medicaid beneficiaries can readily secure employment but have chosen to remain unemployed. AR 6726 (noting that Kentucky HEALTH "may impact overall coverage levels if the individuals subject to these demonstration provisions *choose* not to comply with them.") (emphasis added). That is demonstrably false. *See* Pls.' Mot. for Summ. J. at 30. Eighty percent of non-working, non-exempt beneficiaries have exited the labor force altogether. AR 16835. These beneficiaries often have health conditions that limit their ability to work; are disproportionately unskilled and uneducated; and live in economically depressed regions. Yet HHS and Kentucky disregard the unusually high barriers this population faces in securing employment.

First, more than one-third of unemployed beneficiaries subject to the work requirement have at least one serious health limitation; one-fifth report two or more. AR 16836. This group does not qualify as disabled for Supplemental Security Income (SSI) purposes, but may nonetheless be unable to work. AR 16838. And, although Kentucky exempts the "medically frail" from its new work requirements, AR 6774, the Commonwealth's definition of this term leaves many important questions open. For example, it is unclear whether "cancer survivors" are included in the definition of medically frail. AR 13557-13558. The breadth of that definition is incredibly important, given that many non-working, non-exempt beneficiaries have physical limitations that make it difficult to do everyday tasks, such as walking, climbing stairs, and running errands. AR 16838. Even under the most generous definition, however, thousands will fall through the cracks and be deprived of coverage. For these beneficiaries, the same health

limitations that bar them from the workforce prevent them from meeting the community-engagement requirement by training or volunteering. *Cf.* AR 6774.

Those suffering from mental illness face particular challenges. Thousands of non-disabled beneficiaries have intellectual or mental-health conditions that make it difficult for them to "concentrat[e], remember[], or mak[e] decisions." AR 16838. And, because mental illness is "characterized by remission and relapse," Yoichiro Takayanagi et al., *Accuracy of Reports of Lifetime Mental and Physical Disorders: Results from the Baltimore Epidemiological Catchment Area Study*, 71 JAMA Psychiatry 273, 278 (2014), *available at* https://tinyurl.com/yaskqf3r, beneficiaries could be in a state of recovery at the time they are assessed and thus not qualify as "medically frail." Their condition, however, could deteriorate rapidly, making it difficult to hold down a job and placing continued coverage at risk.

Second, Kentucky's non-working, non-exempt beneficiaries face even higher barriers to employment due to a lack of education and skills. *See* Board of Governors of the Federal Reserve System, A Perspective from Main Street: Long-Term Unemployment and Workforce Development 30, 42 (Dec. 2012), *available at* https://tinyurl.com/yaxnfqf8 ("Federal Reserve"). Nearly 80% of this group has no education beyond high school, while roughly 25% has less than that. AR 16838. Because "a high percentage of [open jobs] require higher education or specialized training," uneducated workers face the highest hurdles in finding work. Federal Reserve, *supra*, at 5. Compounding these issues, finding work becomes more difficult the longer a beneficiary is unemployed, because "skills atrophy, networks erode, and personal barriers to re-employment" increase once a worker exits the workforce. Rockefeller Foundation, Long-Term Unemployment 13 (May 2013), *available at* https://tinyurl.com/y7egp6wt.

To make matters worse, this population disproportionately lives in economically depressed rural areas. AR 16840. Between 2009 and 2017, 32 of Kentucky's 85 rural counties saw unemployment rise by 10-30%. AR 24416. Moreover, a growing number of Kentucky's counties—nearly half—were classified for 2019 as Labor Surplus Areas, meaning that they "have more available workers than jobs." Ashley Spalding, *Growing Number of Kentucky Counties Have More Available Workers Than Jobs*, Ky. Ctr. for Econ. Policy: KY Policy Blog (Oct. 2, 2018), *available at* https://tinyurl.com/y6u2jqom. Those "available workers" are often trapped in these areas, because the rural unemployed often do not have a reliable source of transportation to and from a potential job. Federal Reserve, *supra*, at 7. Indeed, 11% of Kentucky's non-working, non-exempt population has no access to a vehicle. AR 16836. HHS and Kentucky's suggestion that these beneficiaries—unable to work, lacking skills, or marooned in depressed communities—require only "encouragement" in order to find a job is misguided.

But even those lucky enough to have a job are not safe. Kentucky HEALTH threatens to disenroll roughly 55,000 working Kentuckians from Medicaid. AR 13200-13201. In order to maintain coverage throughout the year, Kentucky HEALTH requires that enrollees work at least the equivalent of 20 hours a week for 48 weeks a year for a total of 960 hours. AR 13199. Beneficiaries who fail to meet this quota are suspended from Medicaid. AR 6775. This framework "does not seem to reflect the reality" of many beneficiaries' work lives. AR 13198. About 21,000 Kentucky Medicaid beneficiaries work at least 960 hours a year, but do not do so over 48 weeks. AR 13200. Another 34,000 workers do not clock 960 hours annually. AR 13201. This is not for lack of trying. Hours are nearly always outside the control of the worker; "[f]or example, poor sales may result in retail workers being called in for fewer hours than scheduled." Jessica Gehr, Ctr. for Law & Soc. Policy, Policy Brief: Doubling Down: How Work

Requirements in Public Benefit Programs Hurt Low-Wage Workers 4 (June 2017), *available at* https://tinyurl.com/y9vk2adc. And, given the uncertainty of part-time schedules, it will be difficult for beneficiaries to make up for lost hours by volunteering or training. *See id*. at 2.

The large majority of both working and non-working beneficiaries who lose Medicaid will lose their health coverage altogether. The majority of Kentucky's non-working population lacks the means to obtain commercial coverage—roughly 63% of this population is below the federal poverty level, AR 16838, and is therefore ineligible for federal subsidies available for health insurance through the health insurance exchanges, 26 U.S.C. § 36B; 42 U.S.C. § 18071. Most working beneficiaries earn just enough to be ineligible for subsidies, but are not eligible for employer-sponsored insurance. AR 13201-13202. Imposing a work requirement will simply push these beneficiaries into the ranks of the long-term uninsured.

It will also risk the continued coverage of these beneficiaries' children. Over 100,000 nonexempt enrollees have children under the age of 18. AR 16833, 16835. The health coverage of a parent and child is closely intertwined: "Whereas children whose parents are insured are almost always insured themselves, 21.6 percent of children whose parents are uninsured are also uninsured." AR 18207; *see also* AR 12918. In other words, "when parents lose coverage, so do their children." AR 18207.

In sum, Kentucky HEALTH will not meaningfully "encourage" beneficiaries to "attain or retain financial independence." AR 6724. Thinly veiled threats, or "incentives," *id.*, will not help beneficiaries enter the workforce or obtain steadier employment. Thousands of Medicaid beneficiaries medically cannot work, face serious difficulties in finding employment, or work too inconsistently to meet the work requirement. Holding health coverage hostage will only exacerbate these problems.

B. Losing Medicaid Coverage Will Make Beneficiaries Sicker And Possibly Even Lead To Premature Death.

Depriving beneficiaries of coverage can devastate their health. *See* Pls.' Mot. for Summ. J. at 32-34. When Kentucky expanded Medicaid eligibility, enrollment swelled because patients had an acute need for affordable health care. The uninsured rate in Kentucky fell from 20.4% in 2013 to 7.8% in 2016. Dan Witters*, Kentucky, Arkansas Post Largest Drops in Uninsured Rates*, Gallup (Feb. 8, 2017), *available at* https://tinyurl.com/y9mb4mxt. The uninsured rate for the low-income population dropped even more dramatically, plummeting from 40.2% to 8.6% during a similar timeframe. AR 13534. After Kentucky expanded Medicaid eligibility, newly covered adults experienced a 41 percentage point increase in having a usual source of care, and a 23 percentage point increase in being in "excellent health." AR 16734.

Kentucky HEALTH reverses course. Some may die prematurely as a result. Indeed, one life is saved for approximately every 250-300 people who gain coverage. *See, e.g.*, Benjamin D. Sommers et al., *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 New Eng. J. Med. 586, 590 (2017), *available at* https://tinyurl.com/ycmstj4f ("*Recent Evidence*"); *see also* Randall R. Bovbjerg & Jack Hadley, *Why Health Insurance Is Important*, Health Policy Briefs (Urban Inst., Washington, D.C.), Nov. 2007, at 1, *available at* https://tinyurl.com/y9b2prz5 ("Death risk appears to be 25 percent or higher for [uninsured] people with certain chronic conditions, which led to the [Institute of Medicine] estimate of some 18,000 extra deaths per year").

Rolling back Medicaid eligibility places the thousands of Kentuckians who rely on the program for the prevention and early detection of life-threatening diseases in peril. Leighton Ku et al., Henry J. Kaiser Family Found., Date Note: Medicaid's Role in Providing Access to Preventive Care for Adults 2-3 (May 17, 2017), *available at* https://tinyurl.com/ybaouhne

("Preventive Care"). Preventive services enable early intervention, which can prevent, delay, or minimize the effects of often fatal diseases and conditions. *See, e.g.*, Todd P. Gilmer, *The Growing Importance of Diabetes Screenings*, 33 Diabetes Care 1695 (2010), *available at* https://tinyurl.com/y75mex4d. After Kentucky expanded Medicaid in 2014, preventive screenings dramatically increased: Between 2013 and 2014, Kentucky saw a 30% increase in breast cancer screenings and a 16% increase in colorectal cancer screenings. Andrea Callow & Katie Supko, *Medicaid Expansion in Kentucky Leads to Spike in Use of Preventive Services*, Families USA (Oct. 16, 2014), *available at* https://tinyurl.com/yb3qy6wz ("*Medicaid Expansion*"). Preventive services are especially important for Medicaid-eligible adults, because they have "significantly higher rates of chronic conditions and risky health behaviors that may be amenable to preventive care" than other adults. Preventive Care, *supra*, at 1. This is particularly true in Kentucky, which leads the nation in cancer deaths, *Medicaid Expansion*, *supra*; *Leading Cancer Cases and Deaths, Male and Female, 2015*, U.S. Cancer Statistics, Ctrs. for Disease Control & Prevention (June 2018), *available at* https://tinyurl.com/yb8q8t4b; ranks seventh in rate of diabetes, *Diabetes in the United States*, State of Obesity (Sept. 2018), *available at* https://tinyurl.com/y89kkyta; and has the fifth-highest rate of premature death, *Medicaid Expansion*, *supra*.

Those suffering from mental illness would also benefit tremendously from these types of preventive screenings. People with serious mental illness on average die 25 years earlier than the rest of the population. Barbara Mauer et al., Nat'l Ass'n of State Mental Health Program Dirs. (NASMHPD), Med. Dirs. Council, *Morbidity and Mortality in People with Serious Mental Illness* 4 (Oct. 2006), *available at* https://tinyurl.com/ydy34vxd ("*Morbidity and Mortality*"). About 60% of these deaths are due to conditions such as "cardiovascular, pulmonary and

infectious diseases" that could be identified and treated if the proper screenings were conducted. *Id*. at 5.

Moreover, discontinuing coverage for patients who have already been diagnosed with cancer or another chronic disease can be nothing short of catastrophic. Thousands of Kentuckians rely on Medicaid for treatment of these conditions. Indeed, Kentucky's Medicaid expansion led to a nearly 12-percentage point increase in individuals with chronic conditions obtaining treatment. Dep't of Health & Human Servs., ASPE Issue Brief: Medicaid Expansion Impacts on Insurance Coverage and Access to Care 5 (Jan. 18, 2017), *available at* https://tinyurl.com/y9dnald8. This care saves lives. Uninsured patients with cancer, diabetes, and heart disease have much worse survival rates than insured patients suffering from the same diseases. AR 19489, 19492. Rolling back Medicaid eligibility reverses these gains and exposes many chronically ill individuals to a higher chance of premature death.

In addition, depriving Kentuckians of coverage will reverse the increases in access to primary care, ambulatory-care visits, and use of prescription medications resulting from Kentucky's eligibility expansion. *See Recent Evidence*, *supra*, at 588. Curtailing prescription benefits will be particularly harmful in Kentucky, which has the fifth-highest rate of hypertension in the nation. *Hypertension in the United States*, State of Obesity (Sept. 2018), *available at* https://tinyurl.com/y9kzxceo. Successfully treating hypertension—thereby reducing the risk of heart disease—depends on reliable access to prescription drugs. Million Hearts, Dep't of Health & Human Servs., Improving Medication Adherence Among Patients with Hypertension 1 (Feb. 2017), *available at* https://tinyurl.com/y8lkywrk. The same is true of chronic mental illnesses, *Types of Mental Illness*, NAMI California, *available at* https://tinyurl.com/y8eed9ju (last visited Jan. 22, 2019), and diabetes, AR 19795. Kentucky

HEALTH will strip non-working beneficiaries—often those who face the highest risk of developing chronic conditions[2]—of the medication and other treatment they need to live healthy and secure lives.

Losing coverage also negatively impacts beneficiaries' mental health. People who are unemployed already experience high rates of depression. *See, e.g.*, Margaret W. Linn et al., *Effects of Unemployment on Mental and Physical Health*, 75 Am. J. Pub. Health 502, 504 (1985), *available at* https://tinyurl.com/ya7wacj7. Medicaid helps these individuals get the treatment they need. For example, 44% of Ohio Medicaid eligibility expansion enrollees diagnosed with mental health conditions reported that access to mental health treatment became easier after enrolling in Medicaid. AR 12652. Another study showed that increased access led to a 30% reduction in depression rates, even without accounting for increased access to and use of anti-depressants. Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 New Eng. J. Med. 1713, 1717 (2013), *available at* https://tinyurl.com/ydx92br3. Depriving these individuals of this effective source of care risks exacerbating their mental health conditions because, without insurance, they will be far less likely to receive the mental health treatment they need. *Cf. Recent Evidence*, *supra*, at 588.

The negative health consequences of losing coverage fall particularly hard on women. Kentucky HEALTH's exception for pregnant women, AR 6747, is not enough; "[w]omen need regular [pre-conception] care to manage both acute and chronic conditions that could impact the

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[2] Lower-income adults have higher rates of both hypertension and diabetes. Amy Z. Fan et al., *State Socioeconomic Indicators and Self-Reported Hypertension Among US Adults, 2011 Behavioral Risk Factor Surveillance System* (12 Preventing Chronic Disease, no. E27, Feb. 2015), at 1, *available at* https://tinyurl.com/y9nxux5u; Sharon H. Saydah et al., *Socioeconomic Status and Mortality: Contribution of Health Care Access and Psychological Distress Among U.S. Adults with Diagnosed Diabetes*, 36 Diabetes Care 49, 49 (2013), *available at* https://tinyurl.com/y9oflkmz.

health of future pregnancies." March of Dimes, Issue Brief: Medicaid, Work Requirements, and Maternal and Child Health 1, *available at* https://tinyurl.com/y7z4bzfo (last visited Jan. 22, 2019). Indeed, pre-conception conditions such asthma, sexually transmitted infections, and thyroid disease, if left untreated, could harm the woman's health, lead to birth defects, or even trigger miscarriages. *See* Office on Women's Health, *Pregnancy Complications*, Dep't of Health & Human Servs., *available at* https://tinyurl.com/h675epd (last updated June 6, 2018). Kentucky HEALTH exacerbates these risks, because nearly one-third of the women of reproductive age in the Commonwealth get their health coverage through Medicaid. *Gains in Insurance Coverage for Reproductive-Age Women at a Crossroads*, Guttmacher Institute (Dec. 4, 2018), *available at* https://tinyurl.com/y9fxho4s.

The children of parents who lose coverage will also likely suffer negative health outcomes. "A recent study showed that increases in adult Medicaid eligibility levels were associated with a greater likelihood that children in low-income families received at least 1 annual well child visit." AR 18207. These "visits serve as the primary platform for delivery of preventive services to children, and children who receive these visits are more likely to complete immunization schedules and are less likely to have avoidable hospitalizations." *Parental Medicaid Expansions Can Have a Spillover Effect on Children's Health Use*, Am. Acad. of Pediatrics (Nov. 13, 2017), *available at* https://tinyurl.com/y8kaq2m9.

Finally, the dangers of losing health coverage are especially acute for the near-elderly, David W. Baker et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 New Eng. J. Med. 1106 (2001), *available at* https://tinyurl.com/y8q5c9cp ("*Lack of Health Insurance*")—a segment of the population disproportionately likely to lose Medicaid benefits under Kentucky HEALTH, *see* AR 16831. Age is a powerful risk factor for many

diseases, including heart disease and cancer. *See Coronary Heart Disease*, Nat'l Heart, Lung, & Blood Institute, *available at* https://tinyurl.com/ydbayuuo (last visited Jan. 22, 2019); *Age and Cancer Risk*, Nat'l Cancer Institute, *available at* https://tinyurl.com/yclro9hh (posted Apr. 29, 2015). Further, "more than seven in ten 50- to 64-year-olds report having been diagnosed with one or more chronic health conditions, and nearly half have two or more chronic conditions." Gerry Smolka et al., AARP Pub. Policy Inst., *Health Insurance Coverage for 50- to 64-Year-Olds*, Insight on the Issues (AARP Pub. Policy Inst., Washington, D.C.), no. I59, Feb. 2012, at 4, *available at* https://tinyurl.com/yc6fz8y5. Health insurance is particularly important for this group—the uninsured near-elderly are 63% more likely than their privately insured peers to see a decline in their overall health and 23% more likely to have a new physical difficulty that affects walking or climbing stairs. *Lack of Health Insurance*, *supra*, at 1108.

HHS and Kentucky ignore—again—the mountain of evidence showing that eliminating coverage makes beneficiaries sicker. Handcuffing Medicaid eligibility to employment will lead to worse health outcomes.

II. OTHER ASPECTS OF KENTUCKY HEALTH WILL LEAD TO WORSE HEALTH OUTCOMES.

Thousands of beneficiaries who satisfy Kentucky's new work requirements will nonetheless likely lose coverage for failing to pay increased premiums or comply with the plan's onerous reporting requirements. And even those who can shoulder these burdens may effectively lose access to health care because Kentucky HEALTH eliminates non-emergency medical transportation benefits. These Kentuckians will be forced into months-long coverage gaps and experience health outcomes just as bad—or nearly so—as the long-term uninsured.

A. Many Of Those Who Can Satisfy The Work Requirements Will Be Disenrolled Because Of Financial And Administrative Barriers.

HHS claims that Kentucky HEALTH will "provide greater access to coverage for low-income individuals." AR 6726. Not so. The plan's premiums will make Medicaid unaffordable for many Kentuckians. Its penalty for failing to meet administrative requirements will render Medicaid coverage intermittent and unreliable. These features will lead to the disenrollment of thousands of additional Medicaid beneficiaries—many of whom would otherwise satisfy Kentucky's new work requirements. *See* Pls.' Mot. for Summ. J. at 23-27. And, due to Kentucky HEALTH's elimination of non-emergency medical transportation benefits, many Kentuckians lucky enough to retain their Medicaid coverage will not be table to take advantage of those benefits.

For starters, the financial burdens imposed by Kentucky HEALTH will force beneficiaries off the rolls. Kentucky has required nearly all Medicaid beneficiaries to pay copayments for nearly all services. Kentucky Cabinet for Health & Family Servs., What Do I Need to Know About Medicaid Copays? Update for Beneficiaries 1, *available at* https://tinyurl.com/yaw4x4d2 (last visited Jan. 22, 2019) ("Medicaid Copays"). Under Kentucky HEALTH, in lieu of the prior requirement to make copayments, beneficiaries will be required to pay monthly premiums of up to 4% of household income, with a minimum premium of at least $1 per month. AR 6748, 6766; *see also Kentucky HEALTH: Cost Sharing*, Kentucky Cabinet for Health & Family Servs., *available at* https://tinyurl.com/yb28gm8u (last visited Jan. 22, 2019). The penalty for failing to pay these premiums is tied to income level. Beneficiaries with income above 100% federal poverty level who fail to make a *single* premium payment will be locked out of Kentucky HEALTH for six months. AR 6770. These individuals can regain access to their Medicaid benefits only by making up the missed premium payment, paying a new premium

payment to restart their benefits, and attending a course on either health or financial literacy. AR 6773. Those beneficiaries with income at or below 100% federal poverty level who fail to pay their premiums will not be locked out, but instead will revert to the prior requirement to make copayments. AR 6771. According to HHS, these measures will teach beneficiaries how to "utilize commercial market health insurance successfully, thereby" shrinking the Medicaid rolls as beneficiaries successfully "transition from Medicaid to commercial coverage." AR 6725.

HHS is half right: Premiums *will* shrink the Medicaid rolls. But that is not because beneficiaries will now understand the intricacies of the commercial health insurance market; it is because they will no longer be able to afford Medicaid. Most Medicaid recipients are, by definition, low-income, and the slightest increase in financial burden can have a dramatic effect on Medicaid participation. A recent study showed Medicaid participation dropping by *half* when premiums were set at 3%. Melissa B. Buntin et al., Dep't of Health Policy, Vanderbilt Univ. Sch. of Med., Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States 3 (June 2017), *available at* https://tinyurl.com/y7hmahh7. Likewise, while beneficiaries with incomes less than 100% federal poverty level cannot be categorically denied access to medical services, *Medicaid Copays*, *supra* at 2, "the mere existence of the copay will discourage some from seeking care," *The Copays Are Coming, The Copays Are Coming!*, Kentucky Voices for Health (Dec. 12, 2018), *available at* https://tinyurl.com/ya5gewyj. Indeed, research has shown that requiring copayments as small as $1 leads to a reduction in a beneficiary's use of needed services. AR 13139. The premium and cost-sharing requirements will cause many cash-strapped low-income Kentuckians to discontinue coverage and add to the number of patients who experience coverage gaps. This pattern is already being borne out "[i]n Indiana, the model for Kentucky's waiver, [where] 55

percent of individuals either never made a first payment or missed a payment while enrolled." *Waiver Will Harm*, *supra*, at 5.

And Kentucky HEALTH's new penalty for failing to accurately report changes in eligibility will keep people off the rolls. Kentucky, like all other states, requires Medicaid beneficiaries to provide documentation to renew eligibility annually, AR 6756, and to report any change in circumstances affecting eligibility, such as a change in income, AR 6759. But Kentucky HEALTH imposes a drastic new punishment for those who fail to meet these requirements: a six-month lock-out period. AR 6756, 6759-6760. Many will suffer this penalty. Research shows that "complicated" processes or those that "require additional documentation or verification" lead to "reductions in enrollment and retention" of Medicaid-eligible individuals. MaryBeth Musumeci et al., Henry J. Kaiser Family Found., Issue Brief: Re-approval of Kentucky Medicaid Demonstration Waiver 3 (Nov. 2018), *available at* https://tinyurl.com/y9xufxdu.

But even those who are able to check these boxes may effectively lose their benefits. Under Kentucky HEALTH, the Commonwealth will not cover non-emergency medical transportation for most beneficiaries. AR 6762. This puts many rural workers' Medicaid benefits out of reach. The primary reason most people miss medical appointments is because they do not have transportation. The Lewin Group, Inc., Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver 35-36 (Feb. 26, 2016), *available at* https://tinyurl.com/y97ston9. By taking this benefit away from beneficiaries, HHS and Kentucky effectively create a coverage gap within the Medicaid population itself. Now, only those who can get a ride can consistently take advantage of life-saving care such as preventive screenings or treatments for a chronic illness.

B. Gaps In Coverage Are Associated With Negative Health Outcomes.

Periodic gaps in coverage trigger a cascade of negative health effects. Even the short-term uninsured are consistently and significantly less healthy than the insured. Those who lost insurance recently are "two to three times as likely to" report health care access problems than those with consistent coverage, even "after controlling for income, health status, age, and sex." Cathy Schoen & Catherine DesRoches, *Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage*, 35 Health Servs. Res. 187, 203 (2000), *available at* https://tinyurl.com/y743c4jg/. Forty-seven percent of patients who experience a coverage gap report that it hurt their overall health. Benjamin D. Sommers et al., *Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many*, 35 Health Aff. 1816, 1820 (Oct. 2016), *available at* https://tinyurl.com/yc8ubd5z.

Health care delivery breaks down for patients who lack continuous coverage. Many patients cannot afford to keep their primary-care physician or see a specialist during a coverage gap. *Id*. One study calculated that patients with intermittent coverage were five times more likely to be priced out of seeing a doctor than those with consistent coverage. John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061, 2064-65 (2000), *available at* https://tinyurl.com/y7oh3tuj. That study also found that 21.7% of the short-term uninsured could not afford a needed doctor visit, compared to 26.8% of the long-term uninsured and 8.2% of those with coverage. *Id.* at 2066. These numbers "suggest[] that even short-term periods without insurance may cause sizable numbers of people to forgo needed care." *Id*.

Intermittent coverage also reduces access to preventive screenings and treatment. Beneficiaries with coverage gaps are significantly less likely to get mammograms, Pap smears,

or screening for hypertension and high cholesterol. *Id*. at 2065. Then, once conditions arise, coverage gaps make it far more difficult for patients to get needed treatment. The short-term uninsured with hypertension, diabetes, or elevated cholesterol are significantly more likely to be priced out of seeing a physician and unable to access medication than patients with continuous coverage. *Id*. at 2065, 2067. Conditions worsen as they go untreated, ultimately threatening the lives of those with intermittent coverage. Indeed, "interruptions in Medicaid coverage [a]re associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders." Letter from Suzanne Wikle, Ctr. for Law & Soc. Policy (CLASP), to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. 4 (Aug. 10, 2017), *available at* https://tinyurl.com/ybrl62l9.

The negative health effects of coverage gaps are only amplified for beneficiaries with chronic conditions. Beneficiaries "in the middle of treatment for a life-threatening disease" or tied to "daily medications to manage their chronic conditions cannot afford a sudden gap in their care." AR 13175. For example, those with chronic mental illnesses need consistent treatment and reliable access to medication to successfully manage and ultimately overcome their conditions. *See Morbidity and Mortality*, *supra*, at 5-6. Interrupted coverage could compound these patients' issues. In sum, coverage gaps significantly increase the likelihood that beneficiaries will become sick and then have their illnesses and conditions left untreated.

III. COVERAGE GAPS WILL LEAD TO NEGATIVE LONG-TERM FINANCIAL EFFECTS FOR BENEFICIARIES, PROVIDERS, AND THE GOVERNMENT.

HHS asserts that Kentucky HEALTH will "improve[] the sustainability of the safety net." AR 6726. This, too, is wrong. Kentucky HEALTH places undue financial pressure on all stakeholders. *See* Pls.' Mot. for Summ. J. at 25, 28, 32-33. It will further destabilize beneficiaries' financial well-being, while potentially forcing community providers to shut down

or limit services. Meanwhile, the Commonwealth will be faced with increased administrative costs and a sicker—and thus more expensive—patient population.

Patients face the most immediate financial challenges. For starters, Kentucky HEALTH eliminates retroactive eligibility, AR 6756, which allows patients "diagnosed with a serious illness, such as lung cancer or asthma, to begin treatment without being burdened by medical debt prior to their official eligibility determination." AR 13174. And, "[w]ithout retroactive coverage, Medicaid enrollees could face crippling medical debt." *1115 Waiver Element: Retroactive Coverage*, Families USA, *available at* https://tinyurl.com/y7ndexdr (last visited Jan. 22, 2019). There is also "abundant evidence that having health insurance improves financial security," in part by "reduc[ing] bill collections and bankruptcies," *Recent Evidence*, *supra*, at 586, and by reducing the chances of missing a rent or mortgage payment, Emily A. Gallagher et al., *The Effect of Health Insurance on Home Payment Delinquency: Evidence from ACA Marketplace Subsidies*, J. Pub. Econ. (forthcoming) (manuscript at 3) (Dec. 27, 2018), *available at* https://tinyurl.com/ycj64xae. "[D]ecreased risk of out-of-pocket medical expenditures and debt for those who are newly eligible and take up Medicaid" triggers a chain reaction resulting in improved financial health for beneficiaries. Kyle J. Caswell & Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, Med. Care Res. & Rev. 1, 12 (online ed. Sept. 2017), *available at* https://tinyurl.com/ydyqxuha. Health coverage also decreases the risk of unemployment. For those who are working, Medicaid coverage makes it easier to hold down their job; for those who do not have a job, coverage makes it easier to find one. *See, e.g.*, AR 12653. Kentucky HEALTH, by contrast, reinforces a vicious Catch-22: The long-term unemployed are not working in part because they lack coverage, but they cannot obtain coverage in part because they are not working.

Providers, too, will face increased financial strain. "Safety-net providers—consisting of publicly and privately supported hospitals, community health centers, local health departments, and other providers that care for a disproportionate share of vulnerable populations"—are an essential source of care for both the publicly insured and the uninsured. Suhui Li et al., *Private Safety-Net Clinics: Effects of Financial Pressures and Community Characteristics on Closures* 3 (Nat'l Bureau of Econ. Research, Working Paper No. 21648, 2015), *available at* https://tinyurl.com/y9hykkl9. Many of these providers necessarily rely on Medicaid and its associated revenues to combat "increasingly difficult financial conditions." *Id*. Shutting off this stream of revenue could "lead to particularly large increases in rural hospital closures," Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 Health Aff. 111, 111 (2018), *available at* https://tinyurl.com/yddct2ee, where needs are often the greatest. Potential hospital closures would decrease access to all types of care, resulting in far worse health outcomes for the insured and the uninsured alike. *See* Institute of Medicine, Report Brief: America's Uninsured Crisis: Consequences for Health and Health Care 4 (Feb. 2009), *available at* https://tinyurl.com/y989gbwc.

Finally, Kentucky HEALTH will increase certain government expenditures. Simply setting up the administrative system could cost over $180 million in the first six months alone. *See, e.g.*, AR 13350. Further, administering Medicaid will now be more expensive because of the "churn"—the costly pattern of short-term enrollment, disenrollment, and re-enrollment—the program will create. Katherine Swartz et al., *Reducing Medicaid Churning: Extending Eligibility for Twelve Months or to End of Calendar Year Is Most Effective*, 34 Health Aff. 1180, 1180 (2015), *available at* https://tinyurl.com/yajobvdl. The administrative costs "of one person's churning one time (disenrolling and reenrolling) could be from $400 to $600," which, on

average, would increase the cost of covering a non-disabled Medicaid beneficiary by over 10%. *Id*. at 1181.

The Commonwealth will now, in many cases, also have to pay higher medical bills for services provided to its beneficiaries. Kentucky's decision to strip healthy patients of their coverage puts off small bills today in favor of paying larger bills tomorrow. Because Medicaid coverage increases the availability of primary and preventive care, monthly Medicaid expenditures on average "decline the longer that [recipients] are enrolled in the program." Anita Cardwell, Nat'l Acad. for State Health Policy, Revisiting Churn: An Early Understanding of State-Level Health Coverage Transitions Under the ACA 3 (Aug. 2016), *available at* https://tinyurl.com/y7xkszm2. "When individuals delay seeking routine care due to gaps in coverage," however, their "unmet health needs . . . become exacerbated," "increas[ing the] costs associated with" caring for them. *Id*. Kentucky HEALTH ignores this logic and instead accrues for the Commonwealth costly medical bills to be paid when disenrolled beneficiaries regain benefits by re-enrolling at the end of a lock-out period, qualifying for a new exemption, or by surviving to age 64, when the work requirements will no longer apply to them. Kentucky HEALTH will therefore not just harm beneficiaries' health; it will also harm the Commonwealth's financial health.

* * *

HHS has disregarded ample evidence showing that Kentucky HEALTH will not achieve its stated goals. It will not effectively "promote beneficiary financial independence," AR 6724; "improve the health of Medicaid beneficiaries," AR 6723; or "lead to higher quality care at a sustainable cost," AR 6726. Instead, the work requirements, the premiums, the lock-out period, the elimination of non-emergency medical transportation benefits, and the elimination of

retroactive eligibility will simply increase the numbers of the short- and long-term uninsured. HHS and Kentucky never accounted for how this loss of coverage will produce dramatically worse health outcomes. In approving Kentucky HEALTH despite these deficiencies, HHS "entirely failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43. And, in determining that the program will "improve health outcomes" for Medicaid beneficiaries, HHS's decision ran "counter to the evidence before" it. *Id.* The Court should vacate HHS's approval of Kentucky HEALTH and prevent the severe harms that it will inflict on Kentucky Medicaid beneficiaries.

CONCLUSION

For the foregoing reasons and those in Plaintiffs' motion for summary judgment, the Court should vacate HHS's approval of Kentucky HEALTH and grant Plaintiffs' motion.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that, on January 24, 2019, the foregoing was electronically filed through this Court's CM/ECF system, which will send a notice of filing to all counsel, who are registered users.

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