ORAL ARGUMENT SCHEDULED FOR OCTOBER 11, 2019

Nos. 19-5095 & 19-5097

IN THE

United States Court of Appeals for the District of Columbia Circuit

RONNIE MAURICE STEWART, *et al.*,
Plaintiffs-Appellees,

v.

ALEX M. AZAR, II, *et al.*,
Defendants-Appellants.

On Appeal from the United States District Court for the District of Columbia

FINAL BRIEF OF AMERICAN ACADEMY OF PEDIATRICS, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN HEART ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, CYSTIC FIBROSIS FOUNDATION, MARCH OF DIMES, MENTAL HEALTH AMERICA, AND NATIONAL ALLIANCE ON MENTAL ILLNESS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(1), American Academy of Pediatrics, American Cancer Society Cancer Action Network, American College of Physicians, American Heart Association, American Medical Association, American Psychiatric Association, Catholic Health Association of the United States, Cystic Fibrosis Foundation, March of Dimes, Mental Health America, and National Alliance on Mental Illness certify the following:

Parties and Amici. a. All parties, intervenors, and *amici* appearing before the District Court and in this Court are listed in Appellants' briefs.

b. The American Academy of Pediatrics (AAP) is an organization of 67,000 pediatricians committed to protecting the well-being of America's children. AAP has no parent company and no publicly held company holds more than a ten percent interest in AAP. AAP is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The American Cancer Society Cancer Action Network (ACS CAN) is a nonprofit organization that empowers advocates across America to make cancer a top priority for public officials. ACS CAN has no parent company and no publicly held company holds more than a ten percent interest in ACS CAN. ACS CAN is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The American College of Physicians (ACP) is the largest medical specialty

organization and second-largest physician group in the United States comprising 154,000 internal-medicine physicians, related subspecialists, and medical students. ACP has no parent company and no publicly held company holds more than a ten percent interest in ACP. ACP is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The American Heart Association (AHA) is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease. AHA has no parent company and no publicly held company holds more than a ten percent interest in AHA. AHA is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. AMA has no parent company and no publicly held company holds more than a ten percent interest in AMA. AMA is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The American Psychiatric Association (APA) is the nation's largest organization of physicians who specialize in psychiatry comprising more than 38,500 members. APA has no parent company and no publicly held company holds more than a ten percent interest in APA. APA is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The Catholic Health Association of the United States (CHA) is the national leadership organization for the Catholic health ministry, which comprises more than 650 hospitals and 1,600 long-term care and other facilities in all 50 states and the District of Columbia. CHA has no parent company and no publicly held company holds more than a ten percent interest in CHA. CHA is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The Cystic Fibrosis Foundation (CFF) is a nonprofit organization that advocates for policies that promote affordable, adequate, and available healthcare coverage for people with cystic fibrosis. CFF has no parent company and no publicly held company holds more than a ten percent interest in CFF. CFF is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

March of Dimes is a nonprofit organization that leads the fight for the health of all mothers and babies. March of Dimes has no parent company and no publicly held company holds more than a ten percent interest in March of Dimes. March of Dimes is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

Mental Health America (MHA) is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all Americans. MHA has no parent company and no publicly held company holds more than a ten percent interest in

MHA. MHA is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has no parent company and no publicly held company holds more than a ten percent interest in NAMI. NAMI is a "trade association or professional association" for purposes of Circuit Rule 26.1(b).

Rulings Under Review. The rulings under review are listed in Appellants' briefs.

Related Cases. Counsel is not aware of any related cases within the meaning of Circuit Rule 28(a)(1)(C) beyond those identified in Appellants' briefs.

/s/ Kyle M. Druding
Kyle M. Druding

CERTIFICATE IN SUPPORT OF SEPARATE BRIEF

Pursuant to Circuit Rule 29(d), American Academy of Pediatrics, American Cancer Society Cancer Action Network, American College of Physicians, American Heart Association, American Medical Association, American Psychiatric Association, Catholic Health Association of the United States, Cystic Fibrosis Foundation, March of Dimes, Mental Health America, and National Alliance on Mental Illness state that a separate brief is necessary for their presentation to this Court because they alone among the *amici* intending to file represent the distinct interests of healthcare providers and advocacy groups representing populations with particular medical considerations. In addition, a joint brief is not feasible because other *amici* have interests divergent from those of *amici* and their members.

/s/ Kyle M. Druding
Kyle M. Druding

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

Page

TABLE OF AUTHORITIES

Page

CASES:

STATUTES:

OTHER AUTHORITIES:

* Authorities upon which we chiefly rely are marked with an asterisk.

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

Page

GLOSSARY

AAP	American Academy of Pediatrics
ACP	American College of Physicians
ACS CAN	American Cancer Society Cancer Action Network
AHA	American Heart Association
AMA	American Medical Association
APA	American Psychiatric Association
CFF	Cystic Fibrosis Foundation
CHA	Catholic Health Association of the United States
HHS	U.S. Department of Health and Human Services
MHA	Mental Health America
NAMI	National Alliance on Mental Illness

IN THE

United States Court of Appeals for the District of Columbia Circuit

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RONNIE MAURICE STEWART, *et al.*,

Plaintiffs-Appellees,

v.

ALEX M. AZAR, II, *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court for the District of Columbia
No. 1:18-cv-152
District Judge James E. Boasberg

FINAL BRIEF OF AMERICAN ACADEMY OF PEDIATRICS, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN HEART ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, CYSTIC FIBROSIS FOUNDATION, MARCH OF DIMES, MENTAL HEALTH AMERICA, AND NATIONAL ALLIANCE ON MENTAL ILLNESS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

STATEMENT OF INTEREST OF *AMICI CURIAE*

American Academy of Pediatrics (AAP), American Cancer Society Cancer Action Network (ACS CAN), American College of Physicians (ACP), American Heart Association (AHA), American Medical Association (AMA), American Psychiatric Association (APA), Catholic Health Association of the United States (CHA), Cystic Fibrosis Foundation (CFF), March of Dimes, Mental Health

America (MHA), and National Alliance on Mental Illness (NAMI) respectfully submit this brief as *amici curiae* in support of Plaintiffs-Appellees.[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 from lack of access to health coverage and care.

ACS CAN empowers advocates across America to make cancer a top priority for public officials. ACS CAN wants to ensure that cancer patients, survivors, and those who will be diagnosed with the disease have adequate access to healthcare coverage and that any changes to Medicaid do not create unintentional barriers to care for low-income cancer patients.

ACP is the largest medical specialty organization and second-largest physician group in America comprising 154,000 internal medicine physicians, related subspecialists, and medical students. Internal-medicine specialists apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

[1] All parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund the brief's preparation or submission; and no person other than *amici* or their counsel contributed money intended to fund the brief's preparation or submission.

AHA is the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease—the leading cause of death in America. Representing over 100 million Americans living with cardiovascular disease, AHA is committed to improving the health of all Americans by ensuring timely access to high-quality and affordable health coverage.

AMA is the largest professional association of physicians, residents, and medical students in America. AMA's objectives 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 and the District of Columbia.

APA, with more than 38,500 members, is the nation's largest organization of physicians who specialize in psychiatry. Through research, education, and advocacy, APA members work to ensure effective and accessible treatment for everyone with mental health and/or substance-use disorders.

CHA is the national leadership organization for the Catholic health ministry, which 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 ministry's commitment to a just, compassionate healthcare system that protects life.

CFF's mission is to cure cystic fibrosis and enable all people with the disease to lead full, productive lives by funding research and drug development,

promoting individualized treatment, and ensuring access to high-quality, specialized care. CFF advocates for policies that promote affordable, adequate, and available healthcare coverage for people with cystic fibrosis.

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 healthcare is essential to achieving its goals.

MHA is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all Americans. MHA has advocated throughout its history for access to effective mental-health services and support, without undue administrative barriers that prevent individuals from progressing in their recovery.

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 employment seeking. Plaintiffs-Appellees explain why the U.S. Department of

Health and Human Services' (HHS's) approval of Kentucky HEALTH is unlawful. *Amici* write to further explain that Kentucky HEALTH will not achieve its stated goals. Rather than yield better health outcomes and reduce dependence on government programs, Kentucky HEALTH will harm Kentucky Medicaid beneficiaries and increase healthcare providers' costs and government expenditures in the long term. The Court should affirm the judgment below.

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 received access to a full range of healthcare services for the first time. For new beneficiaries, there was a substantial rise in primary-care visits, specialist treatment, screenings, and prescription-drug access, and a drop in costly, inefficient emergency-room visits. Unsurprisingly, new Medicaid recipients reported that their coverage substantially improved their health.

Despite these gains, Kentucky changed course. With HHS's approval, the Commonwealth introduced Kentucky HEALTH, a program that takes Medicaid coverage away from certain beneficiaries if they do not satisfy work requirements—or, as the Commonwealth calls them, "community engagement" requirements. The district court previously 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 comment, HHS re-approved a nearly identical approach. As before, the program's proponents claim work requirements will lift beneficiaries out of unemployment, improve health outcomes, and strengthen social safety nets.

They are wrong. *First*, conditioning eligibility for coverage on employment will lead to mass disenrollment and dramatically worse health outcomes. By the Commonwealth's own estimates, this program will lead to 1.14 million lost coverage months—the equivalent of nearly 100,000 people losing coverage for a year. Many unemployed beneficiaries are not merely jobless but unable to work. Even those actively looking for employment face serious issues in finding and keeping a job that will be exacerbated by withholding healthcare. Many Medicaid beneficiaries who have jobs do not work regular schedules—making it difficult to meet Kentucky HEALTH's one-size-fits-all requirements. HHS and Kentucky do not explain how often-insurmountable barriers to entering the workforce and remaining employed will go away just because the Commonwealth conditions health coverage on employment. Many unemployed and underemployed beneficiaries will simply lose coverage. All will face higher barriers to getting medical treatment they need.

Second, Kentucky HEALTH imposes new burdens and penalties on beneficiaries that jeopardize coverage for the gainfully employed. Kentucky HEALTH requires beneficiaries to report their work status monthly. Any reporting mistake could trigger disenrollment. Kentucky's program requires beneficiaries to shoulder premiums, report any change affecting eligibility, and submit documentation for annual eligibility re-determinations. Under Kentucky HEALTH, 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 become sick. Kentucky HEALTH also terminates non-emergency medical transportation benefits for many beneficiaries, effectively blocking many from using their benefits.

Third, Kentucky HEALTH financially burdens beneficiaries, providers, and the government. 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 down. And Kentucky HEALTH will increase certain government expenses, largely offsetting any fiscal benefits of mass disenrollment. The program will create new administrative expenses and increase Medicaid costs when healthy beneficiaries lose their coverage only to re-enroll when their health worsens and their conditions are costlier to treat.

HHS's latest approval of Kentucky HEALTH ignores all 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). As the district court correctly concluded, that waiver should be set aside once more.

ARGUMENT

I. BY CAUSING THOUSANDS TO DISENROLL FROM MEDICAID, THE WORK REQUIREMENTS WORSEN HEALTH OUTCOMES.

Kentucky's new work requirements will not "improve the health of Medicaid beneficiaries," as HHS asserts. AR6723. Thousands of Medicaid enrollees who can work do, yet many of their jobs are low-paying and do not offer affordable coverage. Kentucky's work requirements will deprive thousands of the neediest beneficiaries of coverage and trigger an avalanche of negative health results. Many of the disenrolled will become sicker, and some could die prematurely.

A. Kentucky HEALTH Strips Thousands Of Their Health Coverage.

The Commonwealth itself projects that Kentucky HEALTH will lead to 1.14 *million* lost coverage months. AR5427. 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 (2018), https://tinyurl.com/ybbs26dq ("*Waiver Will Harm*"). Nearly 165,000 Kentucky Medicaid beneficiaries are not working and not exempt from work requirements. *See* AR16830. Another 55,000 may not receive coverage for the entire year under the new program due to inconsistent work. *See* AR13200–13201. HHS and Kentucky contend that threatening to eliminate Medicaid coverage will "encourage[]" beneficiaries to "attain or retain financial independence." AR6724. Experience shows this to be false. A recent research study on Arkansas's similar work requirements found no significant changes in employment associated with the program, which disenrolled thousands of people within the first six months. Benjamin D. Sommers et al., *Medicaid Work Requirements—Results from the First Year in Arkansas*, New Eng. J. Med. (June 19, 2019), https://tinyurl.com/yxwax483.

HHS and Kentucky apparently assume 165,000 non-working, non-exempt Medicaid beneficiaries can readily secure employment but have chosen to remain unemployed. AR6726 (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, too, is wrong. Eighty percent of non-working, non-exempt beneficiaries have exited the labor force altogether. AR16835. These beneficiaries often have health conditions that limit their ability

to work; are disproportionately unskilled and less-educated; and live in economically depressed regions. Yet HHS and Kentucky disregard unusually high barriers this population faces in securing employment.

First, more than one third of unemployed beneficiaries subject to work requirements have at least one serious health limitation; a fifth report two or more. AR16836. This group does not qualify as disabled for Supplemental Security Income purposes, but may nonetheless be unable to work. AR16838. And, although Kentucky exempts the "medically frail" from its new work requirements, AR6774, that term is troublingly vague. For example, whether cancer survivors are included in the definition of "medically frail" is unclear. AR13557–13558. The breadth of that definition is vitally important, given that many non-working, non-exempt beneficiaries have physical limitations that render difficult everyday tasks such as walking, climbing stairs, and running errands. AR16838. Even under the most generous definition, thousands may 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.* AR6774.

Those suffering from mental illness face particular challenges. Among Medicaid enrollees age 18 to 64, those with serious mental illness are less than half as likely to have worked 20 hours or more in the past week as those without any

health conditions—meaning they are unlikely to meet work requirements. Hefei Wen et al., *Behavioral And Other Chronic Conditions Among Adult Medicaid Enrollees: Implications For Work Requirements*, 38 Health Affairs 660, 663 (Apr. 2019). Thousands of non-disabled beneficiaries have intellectual or mental-health conditions that make "concentrating, remembering, or making decisions" difficult. AR16838. 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), 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." Yet their condition could deteriorate rapidly, making it difficult to hold down a job and placing continued coverage at risk.

Second, many of Kentucky's non-working, non-exempt beneficiaries are unable to find jobs that match their level of education and training. *See* Bd. of Governors of the Fed. Reserve Sys., *A Perspective from Main Street: Long-Term Unemployment and Workforce Development* 30, 42 (2012), https://tinyurl.com/yaxnfqf8 ("Federal Reserve"). Nearly 80% of this group has no education beyond high school, while roughly 25% has even less. AR16838. Because "a high percentage of [available jobs] require higher education or specialized training," less-educated workers face greater hurdles in finding work.

Federal Reserve, *supra*, at 5. Long-term unemployment compounds these issues because "skills atrophy, networks erode, and personal barriers to re-employment" increase over time. Rockefeller Found., *Long-Term Unemployment* 13 (2013), https://tinyurl.com/y7egp6wt.

To make matters worse, this population disproportionately lives in economically depressed rural areas. AR16840. Between 2009 and 2017, 32 of Kentucky's 85 rural counties saw unemployment rise by 10% to 30%. AR 24416. Nearly half of Kentucky's counties 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), https://tinyurl.com/y6u2jqom. Those "available workers" are often trapped in these areas, because the rural unemployed frequently 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. AR16836. HHS and Kentucky incorrectly suggest that these beneficiaries—unable to work, lacking skills, or marooned in depressed communities—require only "encouragement" to find a job.

Even those lucky enough to have a job are not spared. Kentucky HEALTH threatens to disenroll roughly 55,000 working Kentuckians from Medicaid.

AR13200–13201. In order to maintain coverage, Kentucky HEALTH requires enrollees work at least the equivalent of 20 hours a week for 48 weeks a year for a total of 960 hours. AR13199. Beneficiaries who fail to meet this quota are suspended from Medicaid. AR6775. This framework "does not seem to reflect the reality" of many beneficiaries' work. AR13198. About 21,000 Kentucky Medicaid beneficiaries work at least 960 hours a year, but do not do so over 48 weeks. AR13200. Another 34,000 workers do not clock 960 hours annually. AR13201. 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, *Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers* 4 (2017), https://tinyurl.com/y9vk2adc. 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 non-working and working beneficiaries who lose Medicaid will lose coverage altogether. Most of Kentucky's *non-working* population lacks the means to obtain commercial coverage—roughly 63% of this population is below the federal poverty level, AR16838, and 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 coverage. AR13201–13202. Imposing work requirements will simply push these beneficiaries into the ranks of the long-term uninsured.

Doing so also risks the continued coverage for beneficiaries' children. Over 100,000 non-exempt enrollees have children under the age of 18. AR16833, 16835. Coverage rates for parents and children are closely linked: "Whereas children whose parents are insured are almost always insured themselves, 21.6 percent of children whose parents are uninsured are also uninsured." AR18207; *see also* AR12918. In other words, "when parents lose coverage, so do their children." AR18207.

In sum, Kentucky HEALTH will not meaningfully "encourage" beneficiaries to "attain or retain financial independence." AR6724. Thinly veiled threats, or "incentives," AR6724, 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 hostage their health coverage will not help.

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

Depriving beneficiaries of coverage can devastate their health. When Kentucky expanded Medicaid eligibility, enrollment swelled because patients had an acute need for affordable healthcare. 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), https://tinyurl.com/y9mb4mxt. The rate for the low-income population dropped even more dramatically, plummeting from 40.2% to 8.6% during a similar timeframe. AR13534. 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." AR16734.

Kentucky HEALTH reverses course. Some may die prematurely as a result. It is estimated that one life may be saved for every 250–300 people who enroll in health 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), https://tinyurl.com/ycmstj4f ("*Recent Evidence*"); *see also* Randall R. Bovbjerg & Jack Hadley, The Urban Inst., *Why Health Insurance Is Important* 1 (2007), 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 imperils thousands of Kentuckians who rely on the program for prevention and early detection of life-threatening diseases. Leighton Ku et al., Henry J. Kaiser Family Found., *Date Note: Medicaid's Role in Providing Access to Preventive Care for Adults* 2–3 (2017), https://tinyurl.com/ybaouhne ("*Preventive Care*"). Preventive services enable early intervention, which can prevent, delay, or minimize the effects of potentially fatal diseases and conditions. *See, e.g.*, Todd P. Gilmer, *The Growing Importance of Diabetes Screenings*, 33 Diabetes Care 1695 (2010), https://tinyurl.com/y75mex4d. After Kentucky expanded Medicaid in 2014, preventive screenings dramatically increased. 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), https://tinyurl.com/yb3qy6wz ("*Medicaid Expansion*"). Preventive services are especially important for Medicaid-eligible adults, who 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 true in Kentucky, which nationally has the highest rate of cancer deaths, *Medicaid*

Expansion, *supra*; *Leading Cancer Cases and Deaths, Male and Female, 2015*, U.S. Cancer Statistics, Ctrs. for Disease Control & Prevention (2018), https://tinyurl.com/yb8q8t4b; the seventh-highest rate of diabetes, *Diabetes in the United States*, State of Obesity (2018), https://tinyurl.com/y89kkyta; and the fifth-highest rate of premature death, *Medicaid Expansion*, *supra*.

Those suffering from mental illness would benefit tremendously from 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 (2006), 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 with proper screenings and treated. *Id.* at 5.

Losing coverage also negatively affects beneficiaries' mental health. People who are unemployed 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). Medicaid helps individuals get needed treatment. For example, a study showed that increased access to mental-health treatment 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), https://tinyurl.com/ydx92br3; *see also* AR12652. Depriving coverage risks exacerbating these individuals' mental-health conditions because they will be far less likely to receive needed treatment. *Cf. Recent Evidence*, *supra*, at 588.

Negative health consequences of losing coverage fall particularly hard on women. Kentucky HEALTH's exception for pregnant women, AR6747, is not enough; "[w]omen need regular [pre-conception] care to manage both acute and chronic conditions that could impact the health of future pregnancies." March of Dimes, *Medicaid, Work Requirements, and Maternal and Child Health* 1, https://tinyurl.com/y7z4bzfo (last visited June 27, 2019). Untreated pre-conception conditions such asthma, sexually transmitted infections, and thyroid disease can harm women's health, lead to birth defects, or trigger miscarriages. *See* Office on Women's Health, *Pregnancy Complications*, Dep't of Health & Human Servs., https://tinyurl.com/h675epd (last updated Apr. 19, 2019). Kentucky HEALTH exacerbates these risks, because nearly one third of 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 Inst. (Dec. 4, 2018), https://tinyurl.com/y9fxho4s.

Kentucky HEALTH also risks the health of children whose parents lose coverage. Children in low-income families are more likely to have an annual well-child visit when adult Medicaid eligibility increases. AR18207. 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 (2017), 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) ("*Lack of Health Insurance*")—a segment of the population disproportionately likely to lose Medicaid benefits under Kentucky HEALTH, *see* AR16831. Age is a powerful risk factor for many diseases, including heart disease and cancer. Teresa Niccoli & Linda Partridge, *Ageing as a Risk Factor for Disease*, 22 Current Biology R741, R741 (2012). 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,

https://tinyurl.com/yc6fz8y5. Health coverage is particularly important for this group—the uninsured near-elderly are 63% likelier than their privately insured peers to see a decline in overall health and 23% likelier to face 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.

II. IMPLEMENTATION OVERSIGHTS WILL LEAD TO WORSE HEALTH OUTCOMES.

Thousands of beneficiaries who satisfy Kentucky's new work requirements may still lose coverage for failing to pay increased premiums or comply with the program's onerous reporting requirements. Even those who can shoulder these burdens may effectively lose healthcare access because Kentucky HEALTH eliminates non-emergency medical-transportation benefits. These Kentuckians face coverage gaps and health outcomes nearly as bad 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." AR6726. Not so. The program's premiums will make Medicaid unaffordable for many Kentuckians. And its penalty for failing to meet administrative requirements will render Medicaid

coverage intermittent and unreliable. These features may lead to disenrollment of thousands more Medicaid beneficiaries—many of whom otherwise satisfy Kentucky's new requirements. And, due to Kentucky HEALTH's elimination of non-emergency medical-transportation benefits, many Kentuckians lucky enough to retain their Medicaid coverage will be unable to use their benefits.

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, http://tinyurl.com/yy3ory7q (last visited June 26, 2019). 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. AR6748, 6766; *see also Kentucky HEALTH: Cost Sharing*, Kentucky Cabinet for Health & Family Servs., https://tinyurl.com/yb28gm8u (last visited June 26, 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. AR6770. These individuals can regain access to 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.

AR6773. Those beneficiaries with income at or below 100% of the federal poverty level who fail to pay premiums will not be locked out, but instead will revert to the prior requirement to make copayments. AR6771. According to HHS, these measures will teach beneficiaries how to "utilize commercial market health insurance successfully, thereby" shrinking Medicaid rolls as beneficiaries successfully "transition from Medicaid to commercial coverage." AR6725.

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 be unable to afford Medicaid. Most Medicaid recipients are, by definition, low-income, and small increases in financial burden can dramatically affect Medicaid participation. A recent study showed Medicaid participation dropping by *half* when premiums were set at 3% of household income. 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 (2017), https://tinyurl.com/y7hmahh7. Kentucky's 4% threshold may lead to an even greater decrease. Premium and cost-sharing requirements will cause many cash-strapped Kentuckians to discontinue coverage or avoid care and add to the number of patients who experience gaps in their care. This is happening already. "In 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.

Kentucky HEALTH's new penalty for failing to accurately report changes in eligibility will also keep people off the rolls. Kentucky, like all other states, requires Medicaid beneficiaries to provide documentation to renew eligibility annually, AR6756, and to report any change in circumstances affecting eligibility, such as a change in income, AR6759. But Kentucky HEALTH imposes a drastic new punishment for those who fail to meet these requirements: a six-month lock-out period. AR6756, 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., *Re-approval of Kentucky Medicaid Demonstration Waiver* 3 (2018), 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. AR6762. This puts many rural workers' Medicaid benefits out of reach. The most common reason patients miss medical appointments is transportation problems. The Lewin Group, Inc., *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation*

(NEMT) Waiver 35–36 (2016), https://tinyurl.com/y97ston9. By taking this benefit away, HHS and Kentucky ensure only those without transportation challenges can consistently take advantage of life-saving care.

B. Disenrollment Will Increase Uncompensated Care Costs For Healthcare Providers, Further Straining Budgets And Local Economies.

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 essential sources of care for both the publicly insured and 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), https://tinyurl.com/y9hykkl9. Many of these providers 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), https://tinyurl.com/yddct2ee, where needs are often the greatest. Estimates suggest Medicaid revenues will decline by 20%–22% for hospitals in Kentucky. Randy

Haught et al., The Commonwealth Fund, *How Will Medicaid Work Requirements Affect Hospitals' Finances?* 3 (2019), https://tinyurl.com/y65aqdlw.

Hospitals in expansion states like Kentucky have benefited from reduced uncompensated care costs, which will now be undone in the Commonwealth. Hospitals in Kentucky could see the largest uncompensated care increases from state implementation of work requirements, as such requirements in the Commonwealth will apply to both traditional and expansion Medicaid populations up to age 64—the percentage change in uncompensated care cost could range from 109% to 158%. *Id*. at 5. Rural hospitals, which have recently been closing at an alarming rate, will be hit hardest by the loss of Medicaid coverage. Hospital closures would decrease access to all types of care, resulting in far worse health outcomes for the insured and uninsured alike. *See* Inst. of Med., *America's Uninsured Crisis: Consequences for Health and Health Care* 4 (2009), https://tinyurl.com/y989gbwc.

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

HHS asserts that Kentucky HEALTH will "improve[] the sustainability of the safety net." AR6726. This, too, is wrong. Kentucky HEALTH places undue financial pressure on all stakeholders. While destabilizing beneficiaries' financial well-being, it may also force community providers to close or limit services.

Meanwhile, the Commonwealth will face increased administrative costs and a sicker—and thus more expensive—patient population.

Patients face the most immediate financial challenges. For example, Kentucky HEALTH eliminates retroactive eligibility, AR6756, 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." AR13174. "Without retroactive coverage, Medicaid enrollees could face crippling medical debt." *1115 Waiver Element: Retroactive Coverage*, Families USA, https://tinyurl.com/y7ndexdr (last visited June 27, 2019). There is "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*, 172 J. Pub. Econ. 67 (2019), https://tinyurl.com/yy6lolxx. "[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), https://tinyurl.com/ydyqxuha.

Health coverage also decreases 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.*, AR12653. 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 if they are not working.

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 healthcare 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), https://tinyurl.com/y743c4jg/. Forty-seven percent of patients who experience a coverage gap report decreased 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 (2016), https://tinyurl.com/yc8ubd5z.

Healthcare 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), https://tinyurl.com/y7oh3tuj. The results of that study "suggest[] that even short-term periods without insurance may cause sizable numbers of people to forgo needed care." *Id*. at 2066.

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), https://tinyurl.com/ybrl62l9. Depriving Kentuckians of coverage will reverse gains in access to primary care, ambulatory-care visits, and use of prescription medications from Kentucky's eligibility expansion. *See Recent Evidence*, *supra*, at 588.

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. 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., *Medicaid Expansion Impacts on Insurance Coverage and Access to Care* 5 (Jan. 18, 2017), https://tinyurl.com/y9dnald8. This care saves lives. Beneficiaries "in the middle of treatment for a life-threatening disease" or dependent on "daily medications to manage their chronic conditions cannot afford a sudden gap in their care." AR13175. Uninsured patients with cancer, diabetes, and heart disease have much worse survival rates than insured patients suffering from the same diseases. AR 19489, 19492. 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 interferes with necessary treatment and puts patients' lives at risk.

Finally, Kentucky HEALTH will increase government expenditures. Setting up the administrative system could cost over $180 million in the first six months alone. *See, e.g.*, AR13350. Further, administering Medicaid will be more expensive because of "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), https://tinyurl.com/yajobvdl. 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. Based on recent research, adding work requirements could increase the number of nondisabled adults churning off Medicaid in Kentucky from an estimated 108,000 adults to 216,000—a 100% increase. Sara R. Collins et al., The Commonwealth Fund, *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky* 5 (2018), https://tinyurl.com/y4vydrja.

The government will, in many cases, also have to pay higher medical costs. This will affect both the Commonwealth and the federal government, which share responsibility for paying Medicaid costs. *See* Robin Rudowitz, et al., *Medicaid Enrollment & Spending Growth: FY 2018 & 2019*, Henry J. Kaiser Family Found. (Oct. 25, 2018), https://tinyurl.com/y9fjsold. 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 (2016), 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 government 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 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 government'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," AR6723; or "lead to higher quality care at a sustainable cost," AR6726. Instead, the work requirements, premiums, lock-out period, elimination of non-emergency medical-transportation benefits, and 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 dramatically worsen

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.* This Court should affirm the decision below vacating HHS's approval of Kentucky HEALTH and prevent the severe harms that such approval will inflict on Kentucky Medicaid beneficiaries.

CONCLUSION

For these reasons, this Court should affirm the judgment below.

Respectfully submitted,

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August 1, 2019

CERTIFICATE OF COMPLIANCE

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I certify that on August 1, 2019, the foregoing was electronically filed through this Court's CM/ECF system, which will send a notice of filing to all registered users.

/s/ Kyle M. Druding
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