UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM et al.,	
Plaintiffs,	
v.	Civil Action No. 1:18-cv-01900
	Hon. James E. Boasberg
ALEX M. AZAR II et al.,	
Defendants.	

BRIEF FOR THE NATIONAL ALLIANCE ON MENTAL ILLNESS AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

STATEMENT OF INTEREST 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. BY CAUSING THOUSANDS TO DISENROLL FROM MEDICAID, ARKANSAS'S WORK REQUIREMENTS WILL LEAD TO FAR WORSE HEALTH OUTCOMES. 4

A. Arkansas Works Will Strip Thousands Of Their Health Coverage. 4

B. Losing Medicaid Coverage Will Make Beneficiaries Sicker And Possibly Even Lead To Premature Death. 8

II. OTHER ASPECTS OF ARKANSAS WORKS WILL LEAD TO WORSE HEALTH OUTCOMES. 12

A. Many Of Those Who Can Satisfy The Work Requirements Will Be Disenrolled Because Of Administrative And Technical Barriers. 12

B. Gaps In Coverage Are Associated With Negative Health Outcomes. 17

III. THE NEW COVERAGE GAPS WILL LEAD TO NEGATIVE LONG-TERM FINANCIAL EFFECTS FOR BENEFICIARIES, PROVIDERS, AND THE GOVERNMENT. 20

CONCLUSION 25

TABLE OF AUTHORITIES

Page

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STATEMENT OF INTEREST

The National Alliance on Mental Illness (NAMI) respectfully submits this brief as *amicus curiae* in support of Plaintiffs.[1]

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. NAMI has a strong interest in ensuring that people with mental health conditions as well as people with other medical conditions and disabilities have full access to services and support in the community, in accordance with their individual needs and preferences.

NAMI and its members are deeply concerned about Arkansas Works—and programs like Arkansas Works—that threaten low-income 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's (HHS's) approval of Arkansas Works is unlawful. Pls.' Mot. for Summ. J., at 13-45 [Dkt. No. 27-1]. NAMI writes to further explain that Arkansas Works will not achieve its stated goals. Far from yielding better health outcomes and reducing dependence on government programs, Arkansas Works will harm the health of Arkansas Medicaid beneficiaries and increase health care provider and government expenditures in the long term. The Court should vacate HHS's approval of Arkansas Works.

[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 *amicus curiae*, its members, or its counsel made any monetary contribution intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

In 2014, Arkansas expanded Medicaid eligibility to over 225,000 newly eligible beneficiaries. That expansion dramatically improved health outcomes. Hundreds of thousands of Arkansans 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, Arkansas has decided to change course. With HHS's approval, the State has introduced and begun to implement Arkansas Works, a program that will take Medicaid coverage away from certain beneficiaries if they do not satisfy the work activity requirements. The plan's proponents assert that these new Medicaid work activity requirements will lift beneficiaries out of unemployment, improve health outcomes, and promote continuity of coverage.

They are wrong. *First*, conditioning eligibility for coverage on employment will lead to mass disenrollment and health outcomes that dramatically worsen over time. Most of Arkansas's unemployed beneficiaries are not merely jobless; they are unable to work. The State currently has an estimated 39,000 unemployed Medicaid beneficiaries who do not fall within any exemption to the work requirements. Of those, 30,000 have left the labor force altogether, often because of a physical or mental health condition that limits their ability to work. And even those who are actively looking for employment face an array of obstacles in finding and keeping a job that are not erased by taking away their health care. HHS and Arkansas do not explain how these often-insurmountable barriers to entering the workforce and remaining employed will go

away just because the State has made employment a condition of eligibility for Medicaid coverage. Instead, these unemployed low-income beneficiaries will simply lose coverage. All will face higher barriers between them and the medical treatment they need. And some will get sicker and even die prematurely.

Second, Arkansas Works creates a thicket of rules and requirements that jeopardize the coverage of even the gainfully employed. Arkansas Works requires Medicaid beneficiaries to report their work status on a monthly basis according to a new set of complicated rules. Any reporting mistake or failure to meet the monthly reporting time frame can lock beneficiaries out of coverage for up to nine months, creating a steady churn of people losing coverage only to re-gain it in the new year, after they have already become sick or experienced a worsening of a chronic condition. Intermittent, unreliable coverage is little better than being permanently uninsured.

Third, Arkansas Works financially burdens beneficiaries, providers, and the State. Losing benefits exposes former beneficiaries to list-price medical bills and the threat of bankruptcy. Without a reliably insured patient population, rural providers could shut their doors and move to more financially viable parts of the State or out of Arkansas altogether. And Arkansas Works will increase certain government expenses, largely offsetting the fiscal benefits of mass disenrollment. The plan will create new administrative expenses, as well as increase program costs, when healthy beneficiaries lose their coverage only to re-enroll when their health has worsened and they have become sick and are more costly to treat.

HHS's approval of Arkansas Works ignores all this evidence, which undercuts the plan's stated goal of improving health outcomes. By prompting mass disenrollment, the plan will devastate Arkansas beneficiaries and their families. Moreover, the plan's new lock-out periods

belie supporters' assertions that Arkansas Works will lead to continuity of coverage. HHS's explanation for granting the waiver therefore "runs counter to the evidence before the agency." *Motor Vehicles 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, ARKANSAS'S WORK REQUIREMENTS WILL LEAD TO FAR WORSE HEALTH OUTCOMES.

Arkansas's new work requirements will not "improv[e] health outcomes," as HHS and the State assert. AR 0015 (Ctrs. for Medicare & Medicaid Servs., Arkansas Works Section 1115 Demonstration, at 6 (Amended Mar. 5, 2018) ("Waiver")). To the contrary, 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. Arkansas Works Will Strip Thousands Of Their Health Coverage.

Nearly 39,000 Arkansas Medicaid beneficiaries are currently not working and not exempt from Arkansas's new work requirements. *See* Anuj Gangopadhyaya et al., Urban Institute, Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know About Them? 7 (May 2018) ("Urban Institute").[2] HHS and Arkansas contend that Arkansas Works will "encourag[e]" these beneficiaries to move "up the economic ladder" by eliminating their Medicaid coverage if they are unable to find employment. AR 0014 (Waiver at 5).

HHS and Arkansas apparently assume that these non-working Medicaid beneficiaries can readily secure employment but have chosen to remain unemployed. That is not only unsupported; it is demonstrably false. *See* Pls.' Mot. for Summ. J. at 18-24. Nearly 30,000, or

[2] *Available* at https://www.urban.org/research/publication/medicaid-work-requirements-arkansas.

76%, of these 39,000 beneficiaries have exited the labor force altogether. Urban Institute, *supra*, at 13. These beneficiaries often have physical or mental health conditions that limit their ability to work; are disproportionately unskilled and uneducated; and, after being unemployed for a long period of time, must overcome widespread stigma. Yet HHS and Arkansas disregard the unusually high barriers this population faces in securing and maintaining employment.

First, nearly one-third of unemployed beneficiaries subject to the work requirement have at least one serious health limitation, and almost one-fifth report two or more serious health limitations. *Id.* at 14. This group does not qualify as disabled for the purposes of Supplemental Security Income (SSI), *id.* at 2, but may nonetheless be unable to work, *id*. at 18. Although Arkansas exempts the "medically frail" from its new work requirements, AR 0028 (Waiver at 19), the State's definition leaves many important questions open. For example, it is unclear whether "cancer patients and recent survivors" are included in the "definition of medically frail." AR 1319. Many of these beneficiaries have physical limitations that make it difficult to do everyday tasks, such as walking, climbing stairs, and running simple errands. Urban Institute, *supra*, at 17. Even though these beneficiaries are unable to work, there is no guarantee they will qualify as "medically frail" and thus be exempt from the new work requirements. Indeed, even under the most generous definition, thousands of beneficiaries will fall through the cracks and be deprived of coverage. For these beneficiaries, the same health limitations that bar many from the workforce prevent them from satisfying the work requirements by training or volunteering. *See* AR 0029 (Waiver at 20).

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." Urban Institute, *supra*, at 17. And, because

mental illness by its very nature "fluctuate[s] over time in severity and functional impact," AR 1341, individuals 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 nearly impossible to hold down a steady job and placing their continued coverage at risk.

Second, Arkansas's population of non-working, non-exempt Medicaid beneficiaries faces even higher barriers to employment due to 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) ("Federal Reserve").[3] More than half of the affected group in Arkansas has no education beyond high school, while roughly a quarter has less than that. *See* Urban Institute, *supra*, at 13. Because "a high percentage of [available jobs] require higher education or specialized training," uneducated workers face the highest hurdles in finding work. Federal Reserve, *supra*, at 5. These disadvantages are compounded because many of Arkansas's unemployed—especially those in rural areas—do not have a reliable source of transportation to and from a potential job. *Id.* at 7 ("Challenging transportation logistics are a hurdle for many unemployed . . . ."). Finally, even non-working beneficiaries with post-high school education will have trouble finding work if they have been unemployed for a long period of time. For workers of all education levels, "skills atrophy, networks erode, and personal barriers to re-employment" increase once an employee exits the workforce. Rockefeller Foundation, Long-Term Unemployment 13 (May 2013).[4]

[3] *Available at* https://www.federalreserve.gov/communitydev/long-term-unemployment-and-workforce-development.htm.

[4] *Available at* https://assets.rockefellerfoundation.org/app/uploads/20130528215222/Long-Term-Unemployment.pdf.

Lastly, stigmatization against the long-term unemployed will make it more difficult for many non-working beneficiaries to land a job. Unemployment status has become a "sorting criterion" for employers. Annie Lowrey, *Caught in a Revolving Door of Unemployment*, N.Y. Times (Nov. 16, 2013).[5] Even for "low- or medium-skilled jobs," it is significantly more difficult for those out of work for nine months or more to be offered an interview. *Id.* In fact, discrimination against the long-term unemployed is so widespread that many jurisdictions—though not Arkansas—have prohibited employers from refusing to consider candidates because they are out of work or discriminating against the long-term unemployed in job listings. Winnie Hu, *When Being Jobless Is a Barrier to Finding a Job*, N.Y. Times (Feb. 17, 2013).[6] This stigma is keenly felt by those with chronic mental conditions such as schizophrenia, as these individuals are likely to be "out of the workforce for many years." AR 1341.

In sum, Arkansas Works will not meaningfully "promot[e] independence" or increase employment. AR 0015 (Waiver at 6). No set of threats or "incentiv[es]," *id*., will encourage the large majority of Arkansas's non-working beneficiaries to enter the workforce. Many in this category are incapable of working, even if they do not formally qualify as disabled. Others are capable of working but are unable to overcome the high hurdles to re-entering the workforce, despite their best efforts. Neither problem will be solved by withholding health coverage from vulnerable Medicaid beneficiaries. Because the large majority of this population lacks the means to obtain commercial coverage—over half are below the federal poverty line, Urban Institute, *supra*, at 16, and therefore ineligible for federal subsidies available for health insurance coverage

[5] *Available at* https://www.nytimes.com/2013/11/17/business/caught-in-unemployments-revolving-door.html.

[6] *Available at* https://www.nytimes.com/2013/02/18/nyregion/for-many-being-out-of-work-is-chief-obstacle-to-finding-it.html.

through the health insurance exchanges, 26 U.S.C. § 36B; 42 U.S.C. § 18071—they will join the ranks of the long-term uninsured.

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. 24-28. When Arkansas expanded Medicaid eligibility in 2014, enrollment swelled because patients had an acute need for affordable and reliable health care. The uninsured rate in Arkansas fell from 22.5% in 2013 to 10.2% in 2016. Dan Witters, *Kentucky, Arkansas Post Largest Drops in Uninsured Rates*, Gallup (Feb. 8, 2017).[7] The uninsured rate for the low-income population dropped even more dramatically, plummeting from 41.8% to 14.2% during a similar timeframe. Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA Internal Med. 1501, 1503 (2016).[8] Among this group, there was a 29% increase in individuals with a primary-care physician and a 24% increase in individuals who received an annual check-up. Jesse Cross-Call, *Medicaid Expansion Has Improved People's Health, Access to Care, and Financial Security*, Center on Budget & Policy Priorities (May 31, 2017).[9] As a result, this population became 42% more likely to say that they were in "excellent" health. *Id.*

Arkansas Works will take away this coverage and its beneficial effects from thousands. Some may die prematurely as a result. Indeed, one life is saved for approximately every 250-300 people who enroll in health coverage. *See, e.g.*, Benjamin D. Sommers et al., *Health Insurance*

[7] *Available at* https://news.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx.

[8] *Available at* https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420.

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Thousands of Arkansans need Medicaid coverage for the "prevention, [and] early detection" of cancer and other deadly diseases. AR 1322. These tests and screenings enable early intervention, which can prevent, delay, or minimize the onset and effects of these—often fatal—diseases. *See, e.g.*, Todd P. Gilmer, *The Growing Importance of Diabetes Screenings,* 33 Diabetes Care 1695 (2010).[12] Indeed, newly enrolled Medicaid beneficiaries following recent state Medicaid eligibility expansions have proven more likely to screen for cervical, prostate, and breast cancer, as well as diabetes, hypercholesterolemia, and HIV. *Recent Evidence*, *supra*, at 588.

Those suffering from mental illness would benefit tremendously from these types of preventative screenings. On average, people with serious mental illness 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*

[10] *Available* at https://www.ncbi.nlm.nih.gov/pubmed/28636831.

[11] *Available at* https://www.urban.org/sites/default/files/publication/46826/411569-Why-Health-Insurance-Is-Important.PDF.

[12] *Available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2890385/pdf/zdc1695.pdf.

Illness 4 (Oct. 2006) ("*Morbidity and Mortality*").[13] 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 life-threatening disease is nothing short of catastrophic. For most of these patients, losing Medicaid means "forgoing their treatment altogether." AR 1318. As a result, uninsured patients with cancer, diabetes, and heart disease have much worse survival rates than insured patients suffering from the same diseases. Benjamin D. Sommers, *State Medicaid Expansion and Mortality, Revisited: A Cost-Benefit Analysis*, 3 Am. J. Health Econ. 392, 400 (2017).[14]

In addition, depriving Arkansans of coverage will reverse the increases in access to primary care, ambulatory-care visits, and use of prescription medications resulting from Arkansas's Medicaid eligibility expansion. *See Recent Evidence*, *supra*, at 588. Curtailing prescription benefits will be particularly harmful in Arkansas, which has the third-highest rate of hypertension in the nation. *Hypertension in the United States*, State of Obesity (Sept. 2018).[15] 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).[16] The same

[13] *Available at* https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

[14] *Available at* https://www.mitpressjournals.org/doi/pdf/10.1162/ajhe_a_00080.

[15] *Available at* https://stateofobesity.org/hypertension/.

[16] *Available at* https://millionhearts.hhs.gov/files/TipSheet_HCP_MedAdherence.pdf.

is true of chronic mental illnesses, *Types of Mental Illness*, NAMI California,[17] and diabetes, Rebecca Myerson et al., *Medicaid Eligibility Expansions May Address Gaps in Access to Diabetes Medications*, 37 Health Aff. 1200, 1200 (2018).[18] Arkansas Works will strip non-working beneficiaries—often those who face the highest risk of developing chronic conditions[19]—of the medication and other treatment they need to live healthy and secure lives.

Finally, 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).[20] Depriving them of coverage risks exacerbating their mental health conditions. Without insurance, they will then be far less likely to receive the mental health treatment they need. *Cf. Recent Evidence*, *supra*, at 588.

Expanding Medicaid eligibility has the reverse effect. Studies have found a 30% reduction in depression rates among new Medicaid enrollees, 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

[17] *Available at* https://namica.org/resources/mental-illness/types-mental-illness/.

[18] *Available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0154.

[19] 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://www.cdc.gov/pcd/issues/2015/14_0353.htm; 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* http://care.diabetesjournals.org/content/36/1/49.full-text.pdf.

[20] *Available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1646287/pdf/amjph00281-0056.pdf.

(2013).[21] With coverage, beneficiaries can get the treatment they need. For example, 44% of Ohio Medicaid expansion enrollees diagnosed with mental health conditions reported that access to mental health treatment became easier after enrolling in Medicaid. Ohio Dep't of Medicaid, Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly, at 3 (Jan. 2017) ("Ohio Report").[22] And a study across 10 Medicaid eligibility expansion states found that the previously uninsured with mental health issues visited hospitals 44% less frequently after eligibility was expanded. Henry J. Kaiser Family Found., Infographic: Medicaid's Role in Behavioral Health (May 2017).[23]

II. OTHER ASPECTS OF ARKANSAS WORKS WILL LEAD TO WORSE HEALTH OUTCOMES.

Thousands of beneficiaries who satisfy Arkansas's new work requirements will nonetheless likely lose coverage for failing to comply with the plan's convoluted and demanding reporting requirements. These Arkansans 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 Administrative And Technical Barriers.

HHS and Arkansas claim that Arkansas Works will promote a "continuity of coverage for individuals." AR 0014 (Waiver at 5). This, too, is wrong. The plan creates a network of administrative and technical burdens that will render Medicaid coverage intermittent and unreliable. Complex reporting requirements will lead to the disenrollment of thousands of

[21] *Available at* https://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

[22] *Available at* https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[23] *Available at* https://www.kff.org/infographic/medicaids-role-in-behavioral-health/.

additional Medicaid beneficiaries—many of whom otherwise satisfy Arkansas's new work requirements. *See* Pls.' Mot. for Summ. J. 19-20.

Already, thousands of Arkansans have lost access to health care because they did not meet Arkansas Works's new reporting requirements. Less than two months ago, the State stripped 8,500 Arkansans of their health benefits for failure to report their employment. Robin Rudowitz & MaryBeth Musumeci, Henry J. Kaiser Family Found., Issue Brief: A Look at State Data for Medicaid Work Requirements in Arkansas 1 (Oct. 2018) ("A Look at State Data").[24] These Arkansans will be locked out of coverage until at least January 1, 2019. *See id*. at 1-2; AR 0031 (Waiver at 22). In the coming months, thousands more will lose their coverage for failing to follow the particulars of these new reporting procedures. A Look at State Data, *supra*, at 2.

Beneficiaries are losing coverage in large part because Arkansas Works's reporting requirements are needlessly complicated. For starters, the State's scheme for what types of activities satisfy the 80-hours-per-month "work" requirement is difficult to navigate. Under the plan, one hour of time does not always equate to one hour of "work." For example, an hour of high school instruction counts as 2.5 work activity hours, while an hour of GED, basic skills, or literacy instruction counts as two work activity hours. Arkansas Dep't of Human Servs., What You Need to Know About the Work Requirement 2 ("What You Need to Know").[25] Likewise, an hour of "[o]ccupational [t]raining" instruction converts to two work activity hours, but an hour of "[u]npaid [j]ob [t]raining" counts as one work activity hour. *Id*. The list goes on. If

[24] *Available at* http://files.kff.org/attachment/Issue-Brief-A-Look-at-State-Data-for-Medicaid-Work-Requirements-in-Arkansas.

[25] *Available at* https://ardhs.sharepointsite.net/ARWorks/work_requirement/flyer.pdf (last visited Nov. 16, 2018).

Arkansans are not exceedingly careful in converting real hours to work activity hours, they face a very real risk of losing coverage.

On top of that, beneficiaries will lose coverage if they fail to comply with Arkansas Works's convoluted system of administrative deadlines. Most working beneficiaries must report their month's "work activity" hours by the fifth of the following month. *Id*. But when and how often exempt non-working beneficiaries must submit documentation depends on the type of exemption they are claiming.[26] For example, non-working beneficiaries who are caring for an incapacitated person must verify their exemption every two months, while those who are receiving unemployment benefits must report every six. Arkansas Dep't of Human Servs., Medical Services Policy Manual, Section G-190: Verification of the Adult Expansion Group Work and Community Engagement Requirement 16 (May 2018).[27] Beneficiaries who qualify for more than one type of exemption—such as individuals who participate in vocational training and later seek drug treatment—are especially at risk of losing coverage if they become lost in this maze of reporting rules and deadlines.

The system gets even more complicated for students. Full-time students working toward a degree at a college, university, or vocational school must report their credit hours *weekly*, even though their "work activity" hours must be reported monthly. Arkansas Dep't of Human Servs., Reporting Student Work Activities.[28] Then, if their credit hours are reported for four consecutive

[26] Arkansas Works creates a number of exemptions to permit certain beneficiaries to continue receiving coverage without complying with the work requirements. AR 0028 (Waiver at 19). For example, the Waiver exempts "[f]ull time students," those "caring for an incapacitated person," and pregnant women. *Id.*

[27] *Available at* https://ardhs.sharepointsite.net/DHSPolicy/DCOPublishedPolicy/Section%20G-100%20Verification%20Standards.pdf.

[28] *Available at* https://ardhs.sharepointsite.net/ARWorks/Resources/Student_Conversion_Chart.pdf (last visited Nov. 16, 2018).

weeks, full-time students qualify for a six-month exemption. *Id.* Meanwhile, part-time students taking fewer than 8 semester credit hours do not qualify for this six-month exemption and must continue to report their "hours of instruction" weekly if they want those hours to count towards the monthly 80-hour "work activity" requirement. *Id*.

Adding to these complications, Arkansas Works requires beneficiaries to report their work hours through an online-only reporting system. What You Need to Know, *supra*, at 3. Many beneficiaries will lose coverage because they are simply unable to access this exclusively web-based system. More than half of Arkansans who will need to report their work hours has no broadband access, and one-quarter has no Internet access at all. Urban Institute, *supra*, at 14. Non-working, non-exempt beneficiaries have even lower rates of Internet access. 61% lack broadband access, while 31% do not have any Internet access. *Id*. Thus, even if they are able to find and maintain jobs, beneficiaries nonetheless are at risk of losing coverage on account of the new work reporting requirements.

Even for beneficiaries with reliable Internet access, Arkansas's online-only reporting system presents an array of obstacles. To set up an online account for reporting, beneficiaries need to receive a written notice, enter a reference number, verify an e-mail address, and then navigate a multi-stage process with more than a dozen steps. *See* What You Need to Know, *supra*, at 3; *see also* MaryBeth Musumeci et al., Henry J. Kaiser Family Found., Issue Brief: An Early Look at Implementation of Medicaid Work Requirements in Arkansas 5-6 (Oct. 2018) ("Early Look").[29] The portal is not mobile-accessible, precluding compliance for the many beneficiaries who rely exclusively on their smartphones for Internet access. Early Look, *supra*,

[29] *Available at* https://www.kff.org/medicaid/issue-brief/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas/view/footnotes/.

at 6. Exacerbating all of these concerns, Arkansas's outreach efforts have not alerted many beneficiaries of their new reporting requirements. *Id.* at 4-5.

It gets even worse. The reporting system has already experienced a battery of technical problems. On September 5, 2018—a reporting deadline for most beneficiaries—the State's system went down. *Id.* at 9. Beneficiaries, even those who satisfied all other of the State's myriad of requirements, were unable to enter their time. Other beneficiaries could not access the portal because the State never sent them a reference number. *Id.* Such administrative snafus have made the already-confusing reporting system nearly impossible to use.

Unlike the plan's convoluted reporting rules, its punishment for failing to report is straightforward: Failing to properly report hours for three months in a row triggers an automatic disenrollment from Medicaid for the remainder of the calendar year. AR 0014 (Waiver at 5). So beneficiaries who fail to properly report their time for January, February, and March will lose their health benefits for the remaining nine months of the year—even if they find work on April 1. 8,500 Arkansans have already lost health benefits for the rest of 2018 for failing to follow this complex set of reporting requirements. *See* A Look at State Data, *supra*, at 1. Another 12,500 beneficiaries are at risk of losing their Medicaid benefits in the next two months because they have not met the requirements for at least one month. *Id*. at 2.

Compared to other Medicaid work requirement schemes, Arkansas Works's lock-out penalty is severe. New Hampshire and Indiana impose no lock-out period at all for failing to report hours. Ctrs. for Medicare & Medicaid Servs., New Hampshire Health Protection Program Premium Assistance 1115 Demonstration 22 (Amended May 7, 2018);[30] Ctrs. for Medicare &

[30] *Available at* https://www.dhhs.nh.gov/pap-1115-waiver/documents/nh-pap-stcs-05072018.pdf.

Medicaid Servs., Healthy Indiana Plan (HIP) 16 (Feb. 1, 2018).[31] And even Kentucky's scheme, which would have locked beneficiaries out for failure to report, capped that period at six months. Ctrs. for Medicare & Medicaid Servs., KY HEALTH Section 1115 Demonstration 5 (Jan. 12, 2018).[32] What's more, this lock-out trigger does not consider the reason a beneficiary failed to report. Beneficiaries who do not report because they did not work and beneficiaries who do not report because they cannot navigate the system's technical intricacies are treated the same. In fact, early studies have shown that Arkansas Works will kick more patients off the rolls for failing to report than failing to work. Early Look, *supra*, at 14.

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. Indeed, those who lost insurance recently are "two or three times as likely to" report health-care-access problems than those without gaps in 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) ("*Uninsured and Unstably Insured*").[33] 47% of patients who experience a coverage gap report that it hurt their overall health. Benjamin D. Sommers et al., *Insurance Churning Rates for Low-*

[31] *Available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

[32] *Available at* https://kentuckyhealth.ky.gov/SiteCollectionDocuments/Kentucky%20HEALTH%20Demonstration%20Approval.pdf.

[33] *Available at* http://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC1089095&blobtype=pdf.

Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many, 35 Health Aff. 1816, 1820 (Oct. 2016) ("*Insurance Churning*").[34]

Health-care delivery simply 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.* at 1820. 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) ("*Unmet Health Needs*").[35] 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 diminishes access to potentially life-saving preventive screenings. Beneficiaries with coverage gaps are significantly less likely to get mammograms, Pap smears, or screening for hypertension and high cholesterol. *Id.* at 2065; *see also* Julia Foutz et al., Henry J. Kaiser Family Found., The Uninsured: A Primer—Key Facts About Health Insurance and the Uninsured Under the Affordable Care Act 12 (Dec. 2017) ("Research has shown that adults who experience gaps in their health insurance coverage are less likely to . . . be up to date with blood pressure or cholesterol checks than those with continuous coverage.").[36]

[34] *Available* at https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455.

[35] *Available at* https://jamanetwork.com/journals/jama/fullarticle/193207.

[36] *Available at* http://files.kff.org/attachment/Report-The-Uninsured-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-Under-the-Affordable-Care-Act.

Then, once those often-preventable conditions arise, coverage gaps make it far more difficult for patients to get the medication or other treatment they need. By some estimates, nearly half of all patients with sporadic coverage will forgo necessary medication during a coverage gap. *Insurance Churning*, *supra*, at 1820; *see also* Henry J. Kaiser Family Found., Fact Sheet: Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured 1 (June 2017) (stating those who need mental health treatment are less likely to receive care during coverage gaps).[37] Similarly, the short-term uninsured who smoke, are obese, or have 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. *Unmet Health Needs*, *supra*, at 2065, 2067. And, as conditions go untreated, they worsen, ultimately threatening the health and lives of those with intermittent coverage. Indeed, "[a] 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders." AR 1314.

These negative health effects of coverage gaps are only amplified for beneficiaries with chronic conditions. The lock-out period creates "a substantial and life-threatening barrier to care" for patients with heart disease. AR 1267. For "cancer patient[s]," as well, a three-month break in coverage—and the interruption in treatment that comes with it—"could be a matter of life or death." AR 1320. Similarly, for Arkansans with cystic fibrosis, "continuous health coverage is a necessity and interruptions in coverage can lead to lapses in care, irreversible lung damage, and costly hospitalizations." AR 1295. Finally, those with chronic mental illnesses need consistent treatment and reliable access to medication to successfully manage and

[37] *Available at* https://www.kff.org/medicaid/fact-sheet/facilitating-access-to-mental-health-services-a-look-at-medicaid-private-insurance-and-the-uninsured/.

ultimately overcome their conditions. *See Morbidity and Mortality*, *supra*, at 5-6. In sum, coverage gaps significantly increase the likelihood that beneficiaries become sick and then have their illnesses and conditions go untreated.

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

In addition to generating worse health outcomes, Arkansas Works places undue financial pressure on all stakeholders. *See* Pls.' Mot. for Summ. J. 26, 29 n.18. It will increase unemployment and bankruptcy rates for patients, while potentially forcing community providers and hospitals to shut down or limit services. Meanwhile, the State will be faced with increased administrative costs and a sicker patient population that it will later cover at greater expense. Patients face the most immediate financial challenges. "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. Study after study shows that "decreased risk of out-of-pocket medical expenditures and debt for those who are newly eligible and take up Medicaid" triggers a chain of events resulting in improved financial outcomes 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).[38] Medicaid coverage also decreases the risk of unemployment. For those who are working, Medicaid coverage makes it easier to hold down their job. *See, e.g.*, Ohio Report, *supra*, at 4; *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, Univ. of Michigan Inst. for Healthcare Policy &

[38] *Available at* http://journals.sagepub.com/doi/abs/10.1177/1077558717725164?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed.

Innovation (June 27, 2017).[39] And, for those who do not have a job, Medicaid coverage makes it easier to find one. Ohio Report, *supra*, at 4. Arkansas Works, by contrast, reinforces a vicious cycle: 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. This cycle is likely to disproportionately affect Arkansans suffering with mental illnesses: Roughly 80% of those served by public mental health authorities from 2016 to 2017 were unemployed. Substance Abuse and Mental Health Services Administration (SAMHSA), Arkansas 2017 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System, at 18.[40]

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).[41] But they face "constant threats from increasingly difficult financial conditions." *Id*. Medicaid and its associated revenues provide a partial solution. *Id*. at 5. Indeed, increased eligibility for Medicaid coverage is associated with "substantially lower likelihoods of [hospital] closure." Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 Health Aff. 111, 111 (2018).[42]

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[39] *Available at* http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.

[40] *Available at* https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Arkansas-2017.pdf.

[41] *Available at* https://www.nber.org/papers/w21648.pdf.

[42] *Available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976#.

But the reverse is also true. A plan that rolls back eligibility for Medicaid coverage could "lead to particularly large increases in rural hospital closures," *id.*, where needs are the greatest. These hospital closures would decrease access to primary, specialty, and emergency care, resulting in far worse health outcomes for both the insured and the uninsured. *See, e.g.*, Institute of Medicine, Report Brief: America's Uninsured Crisis: Consequences for Health and Health Care 4 (Feb. 2009).[43]

Finally, Arkansas Works will increase certain government expenditures. To begin with, simply setting up the administrative systems to track and verify exemptions will likely cost tens of millions of dollars. *See, e.g.*, Misty Williams, *Medicaid Changes Require Tens of Millions in Upfront Costs*, Roll Call (Feb. 26, 2018, 5:03 AM) (noting that Kentucky's Medicaid work requirement program could cost $187 million in the first six months).[44] Further, administering Medicaid will now be more expensive for the State because more taxpayer dollars must address the "churn" the plan creates. "Churning" is the costly pattern of short-term enrollment, disenrollment, and re-enrollment, which becomes more frequent with monthly eligibility determinations, such as those under Arkansas Works. 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).[45] The administrative costs to the State "of one person's churning one time (disenrolling and reenrolling) could be from $400 to $600," which,

[43] *Available at* http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf.

[44] *Available at* https://www.rollcall.com/news/politics/medicaid-kentucky.

[45] *Available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1204.

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

On top of those additional administrative costs, the State will now in many cases have to pay higher medical bills for services provided to its beneficiaries. By stripping healthy patients of their coverage, the State will end up caring for sicker and therefore more-costly patients down the road when they re-enroll. Indeed, "[w]hen individuals delay seeking routine care due to gaps in coverage," their "unmet health needs . . . become exacerbated," which "increase[s the] costs associated with" caring for them. 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) ("Revisiting Churn").[46] For example, a patient without a regular primary-care provider will tend "to overuse expensive sources of care like the ER or put off seeing a doctor until their health deteriorates enough to warrant [a much more costly] inpatient episode." Ritesh Banjerjee et al., *Impact of Discontinuity in Health Insurance on Resource Utilization*, 10 BMC Health Servs. Res. 1, 8 (online ed. 2010).[47] Moreover, 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." Revisiting Churn, *supra*, at 3. This pattern—putting off small bills today at the expense of paying larger bills tomorrow—will be repeated at scale when disenrolled beneficiaries regain benefits through the cessation of a lock-out period, new eligibility for an exemption, or by surviving to age 50, when Arkansas Works's work requirements will no longer apply to them. Without continuous coverage, this population will be sicker and therefore more expensive for the

[46] *Available at* https://nashp.org/wp-content/uploads/2016/08/Churn-Brief.pdf.

[47] *Available at* https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/1472-6963-10-195.

State to support in the long run. *See e.g.*, David W. Baker et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 New Eng. J. Med. 1106, 1108 (2011).[48] Arkansas Works will therefore not just harm beneficiaries' health; it will also harm the State's financial health.

* * *

HHS and Arkansas have disregarded ample evidence that shows Arkansas Works will not achieve its stated goals. It will not effectively "incentivize employment," AR 0015 (Waiver at 6); "[i]mprov[e] health outcomes," *id.*; or "[p]rovid[e] continuity of coverage," AR 0014 (Waiver at 5). Instead, the work requirement rules, along with the new reporting requirements, will simply increase the numbers of the short- and long-term uninsured. HHS and Arkansas never accounted for how this loss of coverage will produce dramatically worse health outcomes. In approving Arkansas Works 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 Arkansas Works 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 Arkansas Works and prevent the severe harms that its continuation will inflict on Arkansas Medicaid beneficiaries.

[48] *Available at* https://www.nejm.org/doi/pdf/10.1056/NEJMsa002887.

CONCLUSION

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

Respectfully Submitted,

November 16, 2018

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