**ORAL ARGUMENT NOT YET SCHEDULED**

Nos. 19-5094 & 19-5096

IN THE

# United States Court of Appeals for the District of Columbia Circuit

CHARLES GRESHAM, *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

## BRIEF OF AMERICAN COLLEGE OF PHYSICIANS, AMERICAN HEART ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, ARKANSAS HOSPITAL 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 College of Physicians, American Heart Association, American Medical Association, American Psychiatric Association, Arkansas Hospital 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 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 Arkansas Hospital Association is a non-profit trade association representing hospitals throughout Arkansas and the more than 40,000 individuals working in those institutions to improve the health of their communities. The Arkansas Hospital Association has no parent company and no publicly held company holds more than a ten percent interest in the Association. The Arkansas Hospital Association 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 College of Physicians, American Heart Association, American Medical Association, American Psychiatric Association, Arkansas Hospital 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 its presentation to this Court because it 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

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## GLOSSARY

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| ACP | American College of Physicians |
| 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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CHARLES GRESHAM, *et al.*,
Plaintiffs-Appellees,
v.

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

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On Appeal from the United States District Court for the District of Columbia
No. 1:18-cv-1900
District Judge James E. Boasberg

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**BRIEF OF AMERICAN COLLEGE OF PHYSICIANS, AMERICAN HEART ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, ARKANSAS HOSPITAL 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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## STATEMENT OF INTEREST OF *AMICI CURIAE*

The American College of Physicians (ACP), American Heart Association (AHA), American Medical Association (AMA), American Psychiatric Association (APA), Arkansas Hospital Association, 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]

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.

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 the United States. 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 works 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

[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* contributed money intended to fund the brief's preparation or submission.

physicians who specialize in psychiatry. Through research, education, and advocacy, its members work to ensure effective and accessible treatment for all persons with mental-health and/or substance-use disorders.

Arkansas Hospital Association is a non-profit trade association representing hospitals throughout Arkansas and the more than 40,000 individuals working in those institutions to improve the health of their communities. The Association and its members believe that health coverage is essential to assure access to high-quality care for our fellow Arkansans.

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 provide all people with the disease the opportunity 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.

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 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* 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" employment. Plaintiffs-Appellees explain why the U.S. Department of Health and Human Services' (HHS's) approval of Arkansas Works is unlawful. *Amici* write 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 healthcare providers' costs and government expenditures in the long term. The Court should affirm the judgment below.

## 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 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 drops in costly, inefficient emergency-room visits. Unsurprisingly, new Medicaid recipients reported that their coverage substantially improved their health.

Despite these gains, Arkansas changed course. With HHS's approval, the State implemented Arkansas Works, a program that takes Medicaid coverage away from certain beneficiaries if they do not satisfy work activity requirements. The program's proponents assert the 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 on employment will lead to mass disenrollment and dramatically worse health outcomes. Many unemployed beneficiaries are not merely jobless but unable to work. An estimated 39,000 unemployed Medicaid beneficiaries in Arkansas do not fall within any exemption to the work requirements. Of those, 30,000 have left the labor force altogether, often because of physical or mental-health conditions that limit their ability to work. Those actively looking for employment face serious issues in finding and keeping jobs that will be exacerbated by taking away healthcare. HHS and Arkansas do not explain how often-insurmountable barriers to entering the workforce and remaining employed will go away just because the State 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*, Arkansas Works imposes new burdens and penalties on beneficiaries that jeopardize coverage for the gainfully employed. Arkansas Works requires beneficiaries to report their work status monthly according to a new set of complicated rules. Any reporting mistake or failure to meet the monthly reporting timeframe can lock a beneficiary 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 become sick or experience a worsening of a chronic condition. Intermittent, unreliable coverage is little better than no coverage.

*Third*, Arkansas Works financially burdens beneficiaries, providers, and the government. Losing benefits exposes former beneficiaries to medical bills they cannot afford and the threat of bankruptcy. Without a reliably insured patient population, rural providers could shut down. And Arkansas Works will increase certain government expenses, largely offsetting any fiscal benefit 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 has worsened and their conditions are more costly to treat.

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

## ARGUMENT

### I. BY CAUSING THOUSANDS TO DISENROLL FROM MEDICAID, ARKANSAS'S WORK REQUIREMENTS WORSEN HEALTH OUTCOMES.

Arkansas's new work requirements will not "improv[e] health outcomes," as HHS and the State assert. JA__ [AR0015]. 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 Strips Thousands of Their Health Coverage.

An estimated 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 (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. JA__ [AR0014].

HHS and Arkansas apparently assume that non-working Medicaid beneficiaries can readily secure employment but have chosen to remain

[2] https://urbn.is/2limE7V.

unemployed. That, too, is wrong. Nearly 30,000, or 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 less-educated; 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, andalmost one fifth report two or more serious health limitations. *Id.* at 14. This group may not qualify as disabled for the purposes of Supplemental Security Income, *id.* at 2, but may nonetheless be unable to work, *id*. at 18. Although Arkansas exempts the "medically frail" from its new work requirements, JA__ [AR0028], the State's definition leaves many important questions open. For example, it is unclear whether "cancer patients and recent survivors" will be considered "medically frail." JA__ [AR1319]. 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. Urban Institute, *supra*, at 17. Even though these beneficiaries are unable to work, there is no guarantee they may qualify for that "medically frail"

exemption. Even under the most generous definition, thousands will fall through the cracks and be deprived of coverage. For these beneficiaries, the same health limitations that bar them from the workforce prevent them from meeting the community-engagement requirement by training or volunteering. *See* JA__ [AR0029].

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 necessarily "fluctuate[s] over time in severity and functional impact," JA__ [AR1341], individuals could be in 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 Arkansas'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) ("Federal Reserve").[3] More than half of the affected group in Arkansas has no education beyond high school, while roughly a quarter has even less. *See* Urban Institute, *supra*, at 13.

[3] https://bit.ly/2IrWs5Z.

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. These disadvantages are compounded because many of Arkansas's unemployed—especially in rural areas—lack 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-secondary education struggle finding work if they have been unemployed for a long time. For workers of all education levels, "skills atrophy, networks erode, and personal barriers to re-employment" may increase once an employee exits the workforce. Rockefeller Found., *Long-Term Unemployment* 13 (2013).[4] Stigmatization of the long-term unemployed makes it even 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] 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.* Indeed, discrimination against the long-term unemployed is so widespread that many jurisdictions—though not Arkansas—prohibit employers from refusing to consider

[4] https://bit.ly/2Xw4PUb.

[5] https://nyti.ms/2WoA8E9.

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-health conditions such as schizophrenia, as these individuals are likely to be "out of the workforce for many years." JA__ [AR1341].

In sum, Arkansas Works will not meaningfully "promot[e] independence" or increase employment. JA__ [AR0015]. No 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 unable to work, even if they do not formally qualify as disabled. Others are capable of working but unable to overcome these barriers 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 coverage 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.

[6] https://nyti.ms/2K1bT8s.

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

Depriving beneficiaries of coverage can devastate their health. When Arkansas expanded Medicaid eligibility, enrollment swelled because patients had an acute need for affordable and reliable healthcare. 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 (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).

Arkansas Works deprives thousands of the beneficial effects of coverage. 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) ("*Recent Evidence*"); *see also* Randall R. Bovbjerg & Jack Hadley, The Urban Inst., *Why Health Insurance Is Important* 1 (2007) ("Death risk appears to be 25 percent or higher for

[7] https://tinyurl.com/y9mb4mxt.

[uninsured] people with certain chronic conditions, which led to the [Institute of Medicine] estimate of some 18,000 extra deaths per year.").[8]

Thousands of Arkansans need Medicaid coverage for the "prevention, [and] early detection" of cancer and other deadly diseases. JA__ [AR1322]. 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). Indeed, beneficiaries newly enrolled after 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 benefit tremendously from preventative 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) ("*Morbidity and Mortality*").[9] About 60% of these deaths are due to conditions such as "cardiovascular,

[8] https://urbn.is/2MxdO6R.

[9] https://bit.ly/2Xuf9Mv.

pulmonary and infectious diseases" that could be identified with proper screenings and treated. *Id*. at 5.

Discontinuing coverage for patients who have already been diagnosed with cancer or another life-threatening disease may be nothing short of catastrophic. For most of these patients, losing Medicaid means "forgoing their treatment altogether." JA__ [AR1318]. 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).[10]

Furthermore, depriving Arkansans of coverage will reverse the increases in access to primary care, ambulatory-care visits, and use of prescription medications from Arkansas's Medicaid eligibility expansion. *See Recent Evidence*, *supra*, at 588. Curtailing prescription benefits will be especially harmful in Arkansas, which has the third-highest rate of hypertension in the nation. *Hypertension in the United States*, State of Obesity (last updated Sept. 2018).[11] 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.,

[10] https://bit.ly/2QQxZuU.

[11] https://bit.ly/2MLSfj5.

*Improving Medication Adherence Among Patients with Hypertension* 1 (2017).[12] Arkansas Works will strip non-working beneficiaries—often those facing the highest risk of developing chronic conditions[13]—of the medication and other treatment they need to live healthy and secure lives.

Negative health consequences of losing coverage fall particularly hard on women. Arkansas's exception for pregnant women, JA__ [AR0028], 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, (last visited June 26, 2019).[14] Untreated pre-conception conditions like 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. (last updated Apr. 19,

[12] https://bit.ly/2jGNQPv.

[13] 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), https://bit.ly/2wFd8Bn; 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 (2013), https://bit.ly/2WoBDlL.

[14] https://tinyurl.com/y7z4bzfo.

2019).[15] Arkansas Works exacerbates these risks, because nearly three in ten 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. (2018).[16]

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). Another study across 10 Medicaid 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., *Medicaid's Role in Behavioral Health* (2017).[17]

[15] https://tinyurl.com/h675epd.

[16] https://tinyurl.com/y9fxho4s.

[17] https://bit.ly/2JXEsn2.

## II. IMPLEMENTATION OVERSIGHTS WILL LEAD TO WORSE HEALTH OUTCOMES.

Thousands of beneficiaries who satisfy Arkansas's new work requirements may still lose coverage for failing to comply with the program's convoluted and demanding reporting requirements. These Arkansans will be forced into months-long coverage gaps and experience health outcomes nearly as bad as those of the long-term uninsured.

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

HHS and Arkansas claim that Arkansas Works will promote "continuity of coverage for individuals." JA__ [AR0014]. This is inaccurate. The program creates a network of administrative and technical burdens that will render Medicaid coverage intermittent and unreliable. Complex reporting requirements may lead to disenrollment of thousands more Medicaid beneficiaries—many of whom otherwise satisfy Arkansas's new work requirements.

Already, thousands of Arkansans have lost access to healthcare because they did not meet Arkansas Works's reporting requirements. According to the state's own data, more than 18,000 Arkansans lost coverage in 2018 due to a failure to meet reporting requirements. Arkansas Dep't of Human Servs., *Arkansas Works*

*Program* (2018).[18] Many do not understand the new requirements—nearly half the respondents in a recent survey of Arkansans subject to the new work requirements did not even know if the work requirements applied to them. Benjamin D. Sommers et al., *Medicaid Work Requirements—Results from the First Year in Arkansas*, New Eng. J. Med. (June 19, 2019).[19]

Beneficiaries are losing coverage in large part because Arkansas Works's reporting requirements are needlessly complicated. The State's scheme for what types of activities satisfy the 80-hours-per-month "work" requirement is difficult to navigate. Under the program, one hour of time does not always equate to one hour of "work." For example, one hour of college instruction equals 2.5 work-activity hours, while one hour of GED, basic skills, or literacy instruction counts as 2 work-activity hours. Arkansas Dep't of Human Servs., *Arkansas Works Work and Community Engagement Requirements* (2018).[20] An hour of occupational-training instruction converts to two work-activity hours, but an hour of unpaid job training counts as one work-activity hour. *Id*. The list goes on. If Arkansans are not exceedingly careful in converting real hours to work activity hours, they face real risk of losing coverage.

[18] https://bit.ly/2RPNc2c.

[19] https://tinyurl.com/yxwax483.

[20] https://bit.ly/2YfpwEl.

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*. at 22. But when and how often exempt non-working beneficiaries must submit documentation depends on the type of exemption they are claiming.[21] 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 (2018).[22] 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.

Adding to these complications, Arkansas Works requires beneficiaries to report their work hours either through an online reporting system or, as of

[21] Arkansas Works creates a number of exemptions to permit certain beneficiaries to continue receiving coverage without complying with the work requirements. JA__ [AR0028]. For example, the Waiver exempts "[f]ull time students," those "caring for an incapacitated person," and pregnant women. *Id.*

[22] https://bit.ly/2Z8JUHh.

December 19, 2018, by calling their hours in by phone. Arkansas Dep't of Human Servs., *DHS Expanding Phone Reporting, Outreach for Arkansas Works Enrollees* (Dec. 12, 2018).[23] The previous online-only system was unworkable for many low-income Arkansans. 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. Sixty-one percent lack broadband access, while 31% do not have any Internet access. *Id*. The new phone system may help, but it is unknown how many will be able to reliably call in to report and how many will have heard about the new option. 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 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* MaryBeth Musumeci et al., Henry J. Kaiser Family Found., *An Early Look at Implementation of Medicaid Work Requirements in Arkansas* 5–6

[23] https://bit.ly/2Z4sr2O.

(2018) ("Early Look").[24] Despite the state's assertions that the portal would be mobile-accessible, Arkansas Dep't of Human Servs., *Arkansas Works Work and Community Engagement Requirements* 21,[25] reports indicate that the portal is not truly accessible, precluding compliance for the many beneficiaries who rely exclusively on their smartphones for Internet access. Early Look, *supra*, 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 program'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. JA__ [AR0014]. So beneficiaries who fail to properly report their

[24] https://bit.ly/2IoCA3B.

[25] https://bit.ly/2YfpwEl.

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. As of February 2019, more than 4,000 Arkansans were already at risk of being locked out of their coverage within the next 2 months, putting them at risk of several months without coverage. Arkansas Dep't of Human Servs., *Arkansas Works Program* (2019).[26] If Arkansas is permitted to continue to implement Arkansas Works in the future, every year thousands are likely to be at risk of continuing the cycle of returning to coverage in January only to be kicked off again a few months later.

Compared to other Medicaid work-requirement schemes, the lock-out penalty in Arkansas Works is severe. New Hampshire and Indiana impose no lock-out period for failing to report hours. Ctrs. for Medicare & Medicaid Servs., *New Hampshire Health Protection Program Premium Assistance 1115 Demonstration* 22 (Amended May 7, 2018); Ctrs. for Medicare & Medicaid Servs., *Healthy Indiana Plan (HIP)* 16 (Feb. 1, 2018). And even Kentucky's scheme, which locks beneficiaries out for failure to report, caps the lock-out period at six months. Ctrs. for Medicare & Medicaid Servs., *KY HEALTH Section 1115 Demonstration* 5 (2018). What's more, Arkansas's lock-out trigger does not consider the reason a beneficiary failed to report. Beneficiaries who do not report

[26] https://bit.ly/2xeGNS6.

because they did not work and beneficiaries who do not report because they cannot navigate the system's technical intricacies are treated the same. And early studies indicate that Arkansas Works will disenroll more beneficiaries 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. 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) ("*Uninsured and Unstably Insured*"). Forty-seven percent of patients who experience a coverage gap report that it hurt their overall health. Benjamin D. Sommers et al., *Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many*, 35 Health Aff. 1816, 1820 (2016) ("*Insurance Churning*").

Health-care delivery breaks down for patients who lack continuous coverage. Many patients cannot afford to keep their primary care physician or see a specialist during a coverage gap. *Id.* 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 were. John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061, 2064–65 (2000) ("*Unmet Health Needs*"). 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 (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.").[27]

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

[27] https://bit.ly/2IrhSQw.

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., *Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured* 1 (2017) (stating those who need mental-health treatment are less likely to receive care during coverage gaps).[28] 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. Conditions worsen as they go untreated, ultimately threatening the 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." JA__ [AR1314].

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. JA__ [AR1267]. For cancer patients, a three-month break in coverage—and the interruption in treatment that comes with it—"could be a matter of life or death."

[28] https://bit.ly/2qutCt6.

JA__ [AR1320]. 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." JA__ [AR1295]. Finally, 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. In sum, coverage gaps significantly increase the likelihood that beneficiaries become sick and then have their illnesses and conditions go untreated.

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

In addition to generating worse health outcomes, Arkansas Works places undue financial pressure on all stakeholders. 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 (2017). 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.*, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, Univ. of Michigan Inst. for Healthcare Policy & Innovation (2017).[29] And, for those who do not have a job, Medicaid coverage makes it easier to find one. 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. That will likely 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* 18 (2017).[30]

[29] https://bit.ly/2uYJtl6.

[30] https://bit.ly/2I0WPFD.

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).[31] 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).

But the reverse is also true. A program that rolls back eligibility for Medicaid coverage could "lead to particularly large increases in rural hospital closures," *id.*, where needs are greatest. These hospital closures would decrease access to primary, specialty, and emergency care, resulting in far worse health outcomes for both the insured and uninsured. *See, e.g.*, Inst. of Medicine,

[31] https://bit.ly/2KC6Nix.

*America's Uninsured Crisis: Consequences for Health and Health Care* 4 (2009).[32]

Finally, Arkansas Works will increase certain government expenditures. To start, 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) (noting that Kentucky's Medicaid work requirement program could cost $187 million in the first six months).[33] Further, administering Medicaid will now be more expensive for the State because more taxpayer dollars must address the "churn" the program 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). The administrative costs to the State "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.

[32] https://bit.ly/2Mwiqdl.

[33] https://bit.ly/2HXW8N6.

On top of those additional administrative costs, the State will now in many cases have to pay higher medical bills for services 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 (2016) ("*Revisiting Churn*").[34] 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 (2010).[35] 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

[34] https://bit.ly/2WPbADw.

[35] https://bit.ly/31cMeil.

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 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). 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," JA__ [AR0015]; "[i]mprov[e] health outcomes," *id.*; or "[p]rovid[e] continuity of coverage," *id.* at JA__ [AR0014]. Instead, the new work and 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 dramatically worsen 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.* This Court should affirm the decision

below vacating HHS's approval of Arkansas Works and prevent the severe harms that such approval will inflict on Arkansas Medicaid beneficiaries.

## CONCLUSION

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

Respectfully submitted,

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June 27, 2019

## CERTIFICATE OF COMPLIANCE

1. This document complies with the type-volume limits of Fed. R. App. P. 29(a)(5) and Fed. R. App. P. 32(a)(7)(B) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 6,380 words.

2. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman.

/s/ Kyle M. Druding
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## CERTIFICATE OF SERVICE

I certify that on June 27, 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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