Nos. 20-37, 20-38

In The Supreme Court of the United States

NORRIS COCHRAN, ACTING SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., *Petitioners*,
v.
CHARLES GRESHAM, ET AL., *Respondents*.

STATE OF ARKANSAS, *Petitioner*,
v.
CHARLES GRESHAM, ET AL., *Respondents*.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

BRIEF OF AMICI CURIAE AARP, AARP FOUNDATION, JUSTICE IN AGING, THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS, THE DISABILITY RIGHTS EDUCATION & DEFENSE FUND, THE NATIONAL DISABILITY RIGHTS NETWORK, THE AMERICAN HEART ASSOCIATION, AND THE AMERICAN LUNG ASSOCIATION IN SUPPORT OF RESPONDENTS GRESHAM, ET AL.

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INTEREST OF AMICI CURIAE[1]

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on health security, financial resilience, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity. Among other things, AARP and AARP Foundation advocate for access to quality health care for older adults through litigation and by participating as amici curiae in state and federal courts.

Justice in Aging is a national, nonprofit law organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Justice in Aging conducts training and advocacy regarding Medicare and Medicaid, and provides technical assistance to attorneys from across the country on how to address problems that arise under these programs. Justice in Aging frequently

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[1] In accordance with Supreme Court Rule 37.6, Amici state that: (1) no counsel to a party authored this brief, in whole or in part; and (2) no person or entity, other than Amici, their members, and their counsel have made a monetary contribution to the preparation or submission of this brief. The parties have consented to the filing of this brief.

appears as friend of the court on cases involving health care access for older Americans.

The National Academy of Elder Law Attorneys, Inc. (NAELA) is a professional organization of attorneys concerned with the rights of the elderly and disabled, providing a professional center, including public interest advocacy, for attorneys whose work enhances the lives of people with special needs and of all people as they age. Its member attorneys represent people in New Hampshire and Arkansas affected by the waivers granted by the Department of Health and Human Services and appear frequently as friend of the court. *See, e.g.*, *Hughes v. McCarthy*, 734 F.3d 473, 480–81 (6th Cir. 2013) (Sixth Circuit noting agreement with position advanced by NAELA as friend of court).

The Disability Rights Education and Defense Fund (DREDF) is a national law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. DREDF is committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives. DREDF has significant experience in Medicaid law and policy, given that disabled individuals disproportionately live in poverty and depend on Medicaid services and supports.

The National Disability Rights Network is the non-profit membership organization for the federally

mandated Protection and Advocacy (P&A) and Client Assistance Program (CAP) agencies. The P&As and CAPs were established by Congress to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. There are P&As and CAPs in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the U.S. Virgin Islands) and the Native American Consortium which includes the Hopi, Navajo, and San Juan Southern Piute Nations in the Four Corners.

The American Heart Association (AHA) is a voluntary health organization that, since 1924, has been devoted to saving people from heart disease and stroke—the first and fifth leading causes of death in the United States. AHA and its more than 40 million volunteers work to fund innovative research, fight for stronger public health policies, and provide lifesaving tools and information to prevent and treat these diseases. Based on well-documented research that uninsured and under-insured Americans with heart disease and stroke experience higher mortality rates, poorer blood pressure control, greater neurological impairments, and longer hospital stays after a stroke, AHA has worked to represent the needs and interests of heart disease and stroke patients and advocated making health care more accessible and affordable.

The American Lung Association is the nation's oldest voluntary health organization, representing more than 36 million Americans with lung disease in all 50 states and the District of Columbia. Because

people with or at risk for lung cancer and lung diseases such as asthma, chronic obstructive pulmonary disease, and pulmonary fibrosis need quality and affordable healthcare to prevent or treat their disease, the American Lung Association strongly supports maintaining and increasing access to healthcare, including through the Medicaid program.

Amici are organizations that represent the interests of older adults and people with disabilities and chronic conditions. We file this brief because the Court's decision about the Secretary of the U.S. Department of Health and Human Services's (HHS) approvals of the New Hampshire Granite Advantage Health Care Program (Granite Advantage) and the Arkansas Works Amendment demonstration project (Arkansas Works Amendment program) under Section 1115 of the Social Security Act will affect whether low-income adults in those states have access to life-sustaining health care.

SUMMARY OF ARGUMENT

The expansion of Medicaid in the Patient Protection and Affordable Care Act (the ACA) was a watershed moment for millions of low-income older adults and people with disabilities and chronic conditions. Through Medicaid expansion, people between the ages of 19 and 64 who have incomes at or below 138% of the federal poverty level and who are not considered "disabled" under Medicaid law can qualify for Medicaid if their state expands its program.

Prior to expansion, people who could not afford health care coverage paid a human toll. This toll included not being able to access health care despite being sick or injured, not being able to fill their prescriptions because they could not afford them, dying from diseases that are treatable if discovered early, and plunging into massive debt and even bankruptcy when they had to pay out of pocket for health care in a crisis.

Now, with 38 states and the District of Columbia expanding Medicaid, millions of low-income adults finally have access to the life-sustaining health care coverage that they need. As a result, their health and financial conditions have vastly improved. They are obtaining preventive care, receiving early diagnosis of medical conditions, accessing treatment for illnesses and injuries, and more successfully managing their chronic conditions. Simply put, Medicaid expansion is saving their lives.

A decision reversing the lower court's judgments to vacate the approvals of the Granite Advantage and Arkansas Works Amendment programs would threaten to erase these significant gains. People in the expansion population would once again find themselves without health care coverage. The significant burden of the coverage losses would fall on people ages 50 to 64, and on younger beneficiaries with chronic conditions or functional impairments. Despite being categorized as "able-bodied," these populations face significant health-related challenges that can affect employment. Moreover, even people who meet the program

eligibility requirements could still lose coverage because of the administrative barriers they must overcome to prove their compliance.

The District of Columbia Circuit properly found that the then-Secretary of HHS's approvals of the New Hampshire and Arkansas demonstration projects were arbitrary and capricious because he failed to address the impact on coverage. While the Secretary's Section 1115 waiver authority is broad, the law mandates that approved projects be likely to promote the Medicaid program's objectives. The central objective of Medicaid is to furnish medical assistance to people who cannot afford it. The challenged aspects of these programs do the opposite: they impede that objective and will cause thousands of people to lose their coverage. Thus, the Circuit Court's judgments should be affirmed.

ARGUMENT

I. Medicaid Expansion Vastly Improves The Lives Of Millions Of Older Adults And People With Disabilities And Chronic Conditions Because It Gives Them Access To Health Care Coverage.

The ACA increases access to health care coverage for low-income older adults and people with disabilities and chronic conditions by enabling states to expand their Medicaid programs. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Medicaid is a cooperative federal-state program that provides medical assistance to people in certain low-income populations, such as children and people who are

aged, blind, or have a "disability" within Medicaid's narrow definition. *See* 42 U.S.C. § 1396-1. The ACA makes it possible for people between ages 19 and 64 whose incomes are at or below 138% of the federal poverty level (FPL) and who are not "disabled" under Medicaid law to qualify for coverage if their state elects to expand the program. 42 U.S.C. § 1396d(y) (referred to as "expansion population"); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 585 (2012) (making Medicaid expansion optional for the states).

The result has been that Medicaid expansion is a nationwide success story. Thirty-eight states and the District of Columbia have expanded Medicaid. Kaiser Fam. Found., *Status of State Action on the Medicaid Expansion Decision* (Feb. 4, 2021).[2] Over 12 million Americans in expansion states have gained health care coverage through the expansion. Jesse Cross-Call & Matt Broaddus, *States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession*, Ctr. on Budget & Pol'y Priorities (July 14, 2020);[3] Medicaid & CHIP Payment & Access Comm'n, *Medicaid enrollment changes following the ACA.*[4]

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[2] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[3] https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and.

[4] www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/#ftn1.

The States of Arkansas and New Hampshire are a part of that success story. In New Hampshire, 71,073 people are enrolled its Medicaid expansion program (Granite Advantage) as of January 2021. *See* N.H. Dep't of Health & Hum. Servs., Off. Quality Assurance & Improvement, *New Hampshire Medicaid Enrollment Demographic Trends and Geography* (2021).[5] In Arkansas, around 249,500 adults were enrolled in the expansion program as of June 2019. *See* Kaiser Fam. Found., *Medicaid Expansion Enrollment* (2019).[6]

Indeed, Medicaid expansion has significantly improved the lives of low-income older adults ages 50 to 64 (Pre-Medicare adults) and people with disabilities and chronic conditions who are not classified as "disabled" under Medicaid. To understand how Medicaid expansion has improved their lives, we must first consider their experiences with health care before their states expanded the program.

For many people in this population, access to health care insurance, and thus health care, was impossible because the cost of insurance was out of

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[5] https://www.dhhs.nh.gov/ombp/medicaid/documents/medicaid-enrollment-01312021.pdf.

[6] https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22arkansas%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

their reach. They could not obtain adequate and affordable health insurance in the private markets. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts about the Uninsured Population* 4 (Oct. 2014) ["Key Facts about the Uninsured Population"].[7] They also could not get employer-based insurance because their jobs seldom offered it. *Id.* The few times their jobs did offer it, they could not afford it because they could not pay their share of the premiums. *Id.* They were under age 65 so they did not qualify for Medicare. *Id.* They also did not qualify for Medicaid due to their age and not being classified as "disabled." *Id.*

Unsurprisingly, the lack of health insurance took a heavy toll on their health and finances. Because insurance has been the gateway to receiving health care in the United States, uninsured adults suffered worse health outcomes or even premature death. Jill Bernstein et al., *How Does Insurance Coverage Improve Health Outcomes?*, Mathematica Pol'y Rsch., Inc. 1 (Apr. 2010). Uninsured adults were about three times less likely to be up-to-date with clinical preventive services than those who were insured. *See* Megan Multack, *Midlife Adults Not Getting Recommended Preventative Services*, AARP Pub. Pol'y Inst. (Sept. 11, 2013). They also had higher mortality rates because they were less likely to have been diagnosed at an early stage with heart disease and its risk factors, and were more likely to have undiagnosed cancers treated at later stages. Inst. of Med.,

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[7] http://files.kff.org/attachment/key-facts-about-the-uninsured-population-fact-sheet.

America's Uninsured Crisis: Consequences for Health and Health Care 72–83 (2009).[8]

People with inadequate or no health insurance had financially ruinous health care costs when they had to obtain care and treatment due to a crisis. Their medical costs contributed to overwhelming debt and bankruptcy. One 2010 study estimated that 22 million people were unable to pay for basic necessities like rent, food, and utilities due to medical bills. Sara R. Collins et al., *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief,* The Commonwealth Fund 12, ex. 12 (March 16, 2011).[9]

Without health insurance coverage, a person had to pay the full cost of health services out of pocket. Considering that it cost tens to hundreds of thousands of dollars for medical care for cancer, heart attacks, and many surgeries, only the wealthiest uninsured people had the ability to afford care after a major illness or accident. *See* David Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study, American Journal of Medicine*, 122 Am. J. Med. 741 (2009).

The large number of uninsured adults also increased Medicare costs. Uninsured people who were

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[8] https://www.ncbi.nlm.nih.gov/books/NBK214966/.

[9] https://www.commonwealthfund.org/publications/fund-reports/2011/mar/help-horizon-how-recession-has-left-millions-workers-without.

not yet old enough to qualify for Medicare experienced deteriorated health conditions, but postponed care because they could not afford it. Rachel Garfield et al., *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA* (Feb. 6, 2014);[10] *Key Facts About The Uninsured Population*, *supra*, at 6*;* Lynda Flowers & Edem Hado, *Hear Their Voices: The Experiences of Midlife Adults Who Gained Medicaid Coverage in Four Expansion States*, AARP Pub. Pol'y Inst. 5 (Nov. 2020) ["Hear Their Voices"].[11] They then were sicker when they finally were eligible for Medicare and cost the federal program more money for their care. J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 347 New Eng. J. Med. 143 (2007) (finding uninsured pre-Medicare people required more intensive and costlier care in the Medicare program after the age of 65 years than previously insured adults.).

The adverse impact and cost for people who had conditions like hypertension, heart disease, stroke, or diabetes were far greater than necessary because those conditions respond well to preventive care, which minimizes hospitalizations and medical interventions. *Id.* Once uninsured people with these chronic conditions obtained Medicare, they had 13% more doctor visits, 20% more hospitalizations, and

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[10] https://www.kff.org/report-section/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca-iii-gaining-coverage-getting-care/.

[11] https://www.aarp.org/ppi/info-2020/hear-their-voices.html.

51% higher total medical expenditures from ages 65 to 72 than did the previously insured adults. *Id.* at 143.

Medicaid expansion drastically improved the medical and financial landscape for Pre-Medicare adults and people with disabilities and chronic conditions. For many, obtaining coverage through expansion was life-changing because they were finally getting the care they need. *See* Madeleine Guth et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*, Kaiser Fam. Found. (March 17, 2020) ["The Effects of Medicaid Expansion"];[12] *Hear Their Voices*, *supra*, at 6.

Below are some critical ways Medicaid expansion improves their lives.

1. ***Saves lives and reduces mortality.*** Medicaid expansion saves lives because it provides coverage for beneficiaries to visit physicians and obtain consistent treatment for serious conditions such as cancer, respiratory disease, mental illness, and diabetes. Indeed, a 2019 study found that Medicaid expansion saved the lives of 19,200 older adults ages 55 to 64. Sarah Miller et al., *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, Nat'l Bureau of Econ. Rsch.: Working Paper Series 16 (July 2019).[13]

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[12] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/.

[13] https://www.nber.org/papers/w26081.

Medicaid expansion also reduces mortality rates. *See e.g.*, Sameed Ahmed M. Khatana et al., *Association of Medicaid Expansion With Cardiovascular Mortality*, 4 JAMA Cardiology 671 (2019) (finding counties in states that expanded Medicaid had a significantly smaller increase in cardiovascular mortality rates among middle-aged adults after expansion compared with counties in states that did not expand Medicaid.); Miranda B. Lam et al., *Medicaid Expansion and Mortality Among Patients With Breast, Lung, and Colorectal Cancer*, JAMA Ntwk. Open (Nov. 2020) (finding Medicaid expansion was associated with decreased mortality among patients with lung, breast, and colorectal cancer).[14]

2. ***Improves health outcomes.*** Medicaid expansion allows Medicaid beneficiaries to have access to critical preventive care services. This results in early detection and treatment, yielding better health outcomes. For instance, a 2020 study found that Medicaid expansion significantly improved the physical health of adults ages 50 to 64. Melissa McInerney et al., *ACA Medicaid Expansion Associated With Increased Medicaid Participation and Improved Health Among Near-Elderly: Evidence From the Health and Retirement Study*, 57 Inquiry 1 (2020).[15] It found a 12% reduction in metabolic syndrome; a 32% reduction in complications from metabolic syndrome;

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[14] https://jamanetwork.com/journals/jamanetworkopen/full article/2772535.

[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7388087/.

an 18% reduction in the likelihood of gross motor skills difficulties; and a 34% reduction in compromised activities of daily living. *Id.* Metabolic syndrome is a group of medical conditions that raise a person's risk factor for heart disease, stroke, and type 2 diabetes. Nat'l Heart, Lung, and Blood Inst., U.S. Dep't of Health & Hum. Servs., *Health Topic: Metabolic Syndrome* (Feb. 15, 2021).[16]

Another recent study found that beneficiaries reported that Medicaid expansion had helped them detect previously undiagnosed chronic conditions, improve their health access and status, and improve their physical and mental health. Ann-Marie Rosland et al., *Diagnosis and Care of Chronic Health Conditions Among Medicaid Expansion Enrollees: a Mixed-Methods Observational Study*, 34 J. Gen. Internal Med. 2549 (2019). A Michigan study found that nearly 1 in 3 people in that state's expansion population discovered a previously undiagnosed chronic illness. Kara Gavin, *Expanding Medicaid Means Health Problems Get Found and Health Improves*, Univ. Mich. Health Lab, (Sept. 30, 2019).[17] Half reported their condition improved. *Id.*

Moreover, states that expanded Medicaid saw greater reductions in hospital admissions, lengths of

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[16] https://www.nhlbi.nih.gov/health-topics/metabolic-syndrome.

[17] https://labblog.uofmhealth.org/industry-dx/expanding-medicaid-means-health-problems-get-found-and-health-improves-study-finds.

stay, and hospital costs that ambulatory care can manage than non-expansion states. *See* Harris Meyer, *Medicaid expansion reduced preventable hospitalizations*, Modern Healthcare, (Nov. 4, 2019) (reviewing study examining effect of Medicaid expansion on preventable hospitalizations and costs).[18]

3. Helps people afford their prescription drugs. All 50 states' Medicaid programs provide coverage for outpatient prescription drugs to all categorical eligible people. Ctrs. for Medicare & Medicaid Servs., *Medicaid Prescription Drugs*.[19] For that reason, gaining access to Medicaid through expansion helps people gain access to affordable drugs. Before expansion, low-income adults employed various strategies to reduce their medication costs. *See, e.g.*, *Hear Their Voices*, *supra*, at 7; *see also* Jae Kennedy & Elizabeth Geneva Wood, *Medication Costs and Adherence of Treatment Before and After the Affordable Care Act: 1999–2015*, 106 Am. J. Pub. Health 1804, 1804–06 (2016) (finding cost-related prescription nonadherence among working adults grew from 1999 to 2009 and dropped steeply following 2014 when the ACA established health insurance marketplaces, expanded Medicaid, and classified prescription drugs as an essential health

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[18] https://www.modernhealthcare.com/medicaid/medicaid-expansion-reduced-preventable-hospitalizations.

[19] https://www.medicaid.gov/medicaid/prescription-drugs/.html.

benefit).[20] These strategies included going without needed medications, reducing recommended dosages, and even securing cheaper medications from outside the country. *Hear Their Voices, supra*, at 7. Medicaid expansion has enabled low-income people to afford the medication they need on a more consistent basis.

4. Increases coverage for people with disabilities. Medicaid expansion provides a new pathway for people with disabilities to obtain health care coverage. MaryBeth Musumeci & Kendal Orgera, *People with Disabilities Are at Risk of Losing Medicaid Coverage Without the ACA Expansion*, Kaiser Fam. Found. (Nov. 2, 2020).[21] Prior to expansion, some people with disabilities obtained Medicaid coverage through enrollment in Supplemental Security Income (SSI) because, in most states, SSI beneficiaries are automatically eligible for Medicaid. However, the criteria for SSI eligibility is stringent—employing a definition of disability that requires the individual to be unable to engage in any substantial gainful activity. As such, SSI and thus Medicaid did not cover a majority of people with disabilities and chronic conditions, many of whom were capable of working with proper accommodations and affordable, reliable health care. *Id.* Medicaid expansion allows people to qualify for Medicaid based solely on their income. As a result, the population of people with disabilities

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[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5024360/pdf/AJPH.2016.303269.pdf.

[21] https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/.

eligible for Medicaid greatly expanded. Now, more than 60% of Medicaid adults with disabilities qualify for Medicaid on a non-SSI basis, largely by virtue of the income eligibility expansion. *Id.*

5. *Increases employment for beneficiaries*. Medicaid expansion provides people with health care coverage which, in turn, enables them to find, create, and maintain employment. As a Kaiser Family Foundation research review concludes, "access to affordable health insurance has a positive effect on people's ability to obtain and maintain employment." Larissa Antonisse & Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review*, Kaiser Fam. Found. (Aug. 7, 2018).[22] A 2018 assessment of the Ohio Medicaid expansion population echoes this conclusion. Eighty-three percent of survey respondents reported that having Medicaid coverage made it easier to work. Ohio Dep't of Medicaid, *2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII*, 4 (Aug. 2018).[23] Sixty percent of unemployed respondents reported that having Medicaid coverage made it easier to look for work. *Id.*

6. Improves financial security. Medicaid expansion helps people become more financially secure. Hannah Katch et al., *Taking Medicaid*

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[22] https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[23] https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes, Ctr. on Budget & Pol'y Priorities (Aug. 13, 2018).[24] People in the expansion population have reduced medical debt, reduced delinquencies, improved credit scores, and improved access to credit. Luojia Hu et al., *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing*, Nat'l Bureau of Econ. Rsch. (April 2016).[25] Thus, the expansion helps improve financial wellbeing and prosperity for communities, families, and individuals.

7. Increases health care coverage during the pandemic. Medicaid expansion has helped the Medicaid program fulfill its role as a safety net during the pandemic. For starters, millions more people had immediate access to coverage at the start of the pandemic because their states had expanded Medicaid. *See* Cross-Call, *supra*; Andis Robeznieks, *As COVID-19 Job Losses Mount, Share These Keys to Get Patients Covered*, Am. Med. Ass'n. (Apr. 30, 2020).[26] It also served as another potential source of insurance for people who lost their jobs or income during the

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[24] https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce.

[25] https://www.nber.org/system/files/working_papers/w22170/w22170.pdf.

[26] https://www.ama-assn.org/delivering-care/patient-support-advocacy/covid-19-job-losses-mount-share-these-keys-get-patients.

pandemic. For example, Medicaid enrollment increased 8% during the pandemic. Rachel Garfied et al., *Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements*, Kaiser Fam. Found. (2021) ["Work Among Medicaid Adults"].[27] This increase is because of the economic downturn as well as the Families First Coronavirus Response Act. Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020). That law ties a state's access to temporary enhanced Medicaid matching funds during the pandemic to the maintenance of eligibility and continuous coverage requirements. *Id*.

In sum, Medicaid expansion has been a lifeline for millions of low-income people. It helps them gain access to care, which substantially improves their health and financial wellbeing. Any waiver program that results in coverage losses would have a devastating effect.

II. Restoring The Granite Advantage And Arkansas Works Amendment Programs Will Cause Thousands Of Vulnerable People To Lose Their Health Care Coverage.

The Secretary of HHS's approvals of the New Hampshire and Arkansas demonstration projects threaten to reverse recent coverage gains. Section 1115 of the Social Security Act (SSA) permits the Secretary to allow states to use the Medicaid program

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[27] https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/.

in ways that federal statutes do not otherwise allow, as long as the Secretary determines that the initiative is an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of [the program]." 42 U.S.C. § 1315(a). This waiver authority is broad, providing states a vast arena in which to experiment. That said, the authority is not without limit. For example, the Secretary cannot waive Constitutional rights, such as the right to due process.

More importantly for this case, the waiver authority provides that the Secretary cannot approve a project unless the project is likely to assist in promoting Medicaid's objectives. *Id.* Section 1396-1 of the SSA identifies a central objective of Medicaid is "to furnish . . . medical assistance on behalf of [persons], whose income and resources are insufficient to meet the costs of necessary medical services . . . ." 42 U.S.C. § 1396-1. Unfortunately, the Granite Advantage and Arkansas Works Amendment programs do not "assist in promoting" this objective. Rather, they do the opposite. Granite Advantage would terminate or reduce Medicaid coverage for thousands of low-income residents between ages 19 to 64. The Arkansas Works Amendment Program does not apply to people ages 50 and over, but it would also terminate or reduce Medicaid coverage for thousands of people ages 19 to 49.

This is not mere conjecture. In the first six months of the Arkansas program, more than 18,000 Medicaid beneficiaries were terminated from the state's Medicaid program. Robin Rudowitz et al.,

February State Data for Medicaid Work Requirements in Arkansas, Kaiser Fam. Found. (March 25, 2019).[28] Similarly, outside experts examined the likely impact of Granite Advantage. They found that Granite Advantage's work requirements will lead to terminating from a third to almost a half of New Hampshire's Medicaid expansion beneficiaries:

> Our analysis indicates that between 30 percent and 45 percent of the 51,000 low-income adults subject to the work requirements in New Hampshire — between 15,000 and 23,000 individuals — will likely be terminated within one year because they either can't meet the work requirements or have difficulty completing the necessary paperwork. This will jeopardize their access to health care, as well as reduce revenue for safety-net health care providers.

Leighton Ku & Erin Brantley, *New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage*, The Commonwealth Fund (May 9, 2019).[29]

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[28] https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/.

[29] https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss.

In fact, New Hampshire suspended its program on July 8, 2019, amidst concerns about an unintended loss of coverage for thousands of beneficiaries. Ian Hill et al., *New Hampshire's Experiences with Medicaid Work Requirements: New Strategies, Similar Results*, Urb. Inst. (Feb. 10, 2020);[30] Letter from Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Hum. Services, to Christopher T. Sununu, Governor, N.H., (July 8, 2019).[31] At the time, an estimated 17,000 beneficiaries were scheduled to be notified that they were not in compliance with the rules and could lose Medicaid coverage the next month. Hill et al., *supra*, at vi. The district court issued its decision vacating the program three weeks later, and the program was never restarted. *Id.* In the end, the facts speak for themselves: these projects will cause significant coverage losses for vulnerable beneficiaries. These losses contravene Medicaid's objectives.

A. Labelling the expansion population as "able-bodied" ignores the many people in the population who have chronic conditions and functional limitations.

A significant burden of the coverage losses would fall on expansion population beneficiaries in their 50s and 60s, and on younger beneficiaries with chronic conditions or functional impairments. These

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[30] https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results.

[31] https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf.

people are not eligible for Medicare because they are not 65 and (in most cases) do not meet strict programmatic definitions of "disabled," yet they are relatively more likely to be facing significant health problems. *See* 42 U.S.C. § 1395c (Medicare eligibility standards). Although Arkansas and New Hampshire have referred to them as "able-bodied" (Ark. Br. 8, 10; N.H. Br. 17, 22, 24) this term is deceiving. It hides many harms likely to result from implementing these programs. It also glosses over many of these beneficiaries' needs and vulnerabilities.

For example, the expansion population includes many vulnerable persons who face health problems, chronic conditions, and functional limitations. Medicaid law classifies a beneficiary as either "aged" (age 65 or older) or not. *See, e.g.*, 42 U.S.C. § 1396d(a)(iii). But in reality, some beneficiaries in their 50s or early 60s face many of the same health challenges that confront beneficiaries formally classified as "aged" (i.e., age 65 and older).

Likewise, although Medicaid eligibility rules may classify a person as "disabled" or "not disabled," disability in real life is a continuum. As a result, a Medicaid beneficiary may not be formally "disabled" under Medicaid law, nor "medically frail" or otherwise qualified for a disability-based exemption under a demonstration project's work requirements, but still face significant health-related challenges that can impact their ability to work. *See, e.g.*, NH App. 3741-

42[32] (MaryBeth Musumeci & Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, Kaiser Fam, Found. 3–4 (2017)); *see also* NH App. 24 (discussing exemption for "medically frail" beneficiaries).

Data from the National Center for Health Statistics show that around 40% of working-age Medicaid beneficiaries "have broadly defined disabilities, most of whom are not readily identified as such through administrative records." NH App. 2991 (H. Stephen Kaye, *How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements?*, Living Pol'y Ctr., Univ. of Cal. S.F. Cmty. 2 (Feb. 2018)). Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among New Hampshire's non-elderly Medicaid population who are not receiving SSI due to disability, 49% cited being ill or disabled as the reason for not being employed. NH App. 2271 (Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work*, Kaiser Fam. Found. 10 (Appendix Table 2) (Jan. 2018)).

Other data sources support this proposition. Among Medicaid beneficiaries not classified as aged or disabled, 52% reported serious difficulty with mobility, and 51% noted serious difficulty with cognitive functioning. Forty-two percent experienced serious difficulty with independent living tasks (e.g., shopping). Another 21% reported serious difficulty

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[32] "NH App." refers to the appendix in *Philbrick v. Azar*, 397 F. Supp. 3d 11(D.D.C. 2019).

with daily living activities such as dressing or bathing. MaryBeth Musumeci et al., *How Might Medicaid Adults with Disabilities Be Affected by Work Requirements in Section 1115 Waiver Programs?*, Kaiser Fam. Found. 3–4 (Jan. 2018); *see also* NH App. 2531 (Rachel Garfield et al., *Implications of Work Requirements in Medicaid: What Does the Data Say?*, Kaiser Fam. Found. 2 (June 2018) (prevalence of chronic conditions among non-working Medicaid beneficiaries)).

Problems are particularly more likely for older Medicaid beneficiaries. Prevalence of chronic conditions, including both physical and mental health conditions, increases markedly with age. Based on health care expense data, the Agency for Healthcare Research and Quality found that 57% of persons from ages 55 through 64 have at least two chronic conditions. Steven Machlin et al., *Agency for Healthcare Research and Quality*, *Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions*, *2005*, Figure 1 (May 2008).[33] Another 20.3% of these persons have one chronic condition; only 22.7% of this population have no chronic conditions. *Id*. AARP came to similar conclusions in an analysis of data for the age 50-64 population, finding that 72.5% of this population have at least one chronic condition, and almost 20% experience mental illness. NH App. 3184-85 (AARP Pub. Pol'y Inst., *Chronic Care: A Call to Action for Health Reform* 11–12 (March 2009)).

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[33] https://www.meps.ahrq.gov/data_files/publications/st203/stat203.shtml.

The National Institute on Aging and National Institutes of Health reached similar results based on surveys of tens of thousands of respondents. Sixty percent of respondents from the age of 55 to 64 reported at least one health problem, with 25% reporting at least two problems. For this study, a "problem" was defined as being linked to one of six categories: hypertension, diabetes, cancer, bronchitis/emphysema, heart condition, and stroke. NH App. 3064 (Nat'l Inst. on Aging & Nat'l Insts. Health, *Growing Older in America: The Health & Retirement Study* 23 (March 2007)).

Another marker of health need is an increase in health care expenses. In examining employer-sponsored health care, the Health Cost Institute documented how health care expenses skyrocket with age. Health Care Cost Inst., *2016 Health Care Cost and Utilization Report Appendix*, at 1 (Table A1) (Jan. 2018).[34] For persons from ages 55 to 64, average annual health care expenses were 44% higher than for persons ages 45 to 54, and 116% higher than for persons ages 26 to 44. *Id.*

Finally, health status tends to vary with income, with lower-income persons experiencing more chronic conditions. For persons of at least age 50 with income below 200% of the federal poverty level, 70% report fair to poor health and/or at least one chronic condition. Sara Rosenbaum et al., *Medicaid Work*

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[34] https://www.healthcostinstitute.org/images/pdfs/2016-HCCUR-Appendix-1.23.18-c.pdf.

Demonstrations: What Is at Stake for Older Adults?, Commonwealth Fund (Mar. 19, 2018).[35] This percentage increases to 83% by age 55. *Id.*

All this data shows how low-income beneficiaries in their 50s and 60s—along with some younger low-income beneficiaries with chronic conditions or functional impairments—will be deprived of needed health care and suffer consequences under Granite Advantage's restrictions. The data also show that a similar group of people under age 50 will be deprived of health care under the Arkansas Works Amendment program. This loss of Medicaid coverage has a human cost: less preventive care, greater decline, avoidable deterioration in physical and mental health, and increased mortality.

B. Foreseeable administrative barriers will exacerbate coverage losses and magnify the Programs' unfairness and harm.

The waiver projects impose significant and unfair obligations on low-income adults. Predictable administrative errors and bottlenecks will only exacerbate the number of people losing coverage. "Red tape and paperwork requirements have been shown to reduce enrollment in Medicaid across the board, and people coping with serious mental illness or physical impairments may face particular difficulties meeting these requirements." Ctr. on Budget & Pol'y Priorities, *Taking Away Medicaid for Not Meeting Work*

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[35] https://www.commonwealthfund.org/blog/2018/medicaid-work-demonstrations-what-stake-older-adults.

Requirements Harms Older Americans 2 (Dec. 5, 2018).[36]

This is especially true here because the programs shift administrative obligations to beneficiaries. As a result, beneficiaries are more likely to lose coverage inappropriately because they will have trouble complying with the program's reporting requirements. This will cause many beneficiaries who have met the requirements or qualify for an exemption to still lose their coverage.

For instance, interviews with Arkansas beneficiaries showed that barriers such as difficulty using computers and lack of transportation hampered their ability to comply with reporting requirements. *Work Among Medicaid Adults*, *supra*. A Kaiser Family Foundation study of Arkansas data found that safeguards intended to protect people who should not have been subject to work requirements were complex and difficult to use. MaryBeth Musumeci, *Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018*, Kaiser Fam. Found. 4–5 (June 11, 2019).[37]

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[36] https://www.cbpp.org/sites/default/files/atoms/files/2-2018 health.pdf.

[37] https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/.

New Hampshire found itself in a similar position despite employing many strategies to avoid the problems experienced in Arkansas. *See* Hill et al., *supra*. It ended up suspending its implementation, explaining that it had difficulty reaching beneficiaries. *Id.* News articles reported that some beneficiaries were confused about the state's letters and did not know how to comply. Jason Moon, *Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect*, NHPR (June 18, 2019).[38] As noted above, less than two months into its implementation, an estimated 17,000 beneficiaries faced the possibility of being disenrolled the next month. Hill et al., *supra*, at vi.

These results align with studies of beneficiary reporting requirements for other safety net programs. For example, research on the Temporary Assistance for Needy Families (TANF) program (which provides cash benefits) found that beneficiaries with disabilities and poor health are more likely to lose benefits due to an inability to navigate the system. NH App. 2306-307 (Yeheskel Hasenfeld, et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment,* 78 Soc. Serv. Rev. 304, 306–07 (June 2004)). Likewise, a review of the research finds that the existence of exemptions does not necessarily ameliorate problems because a beneficiary may likely have difficulty understanding and obtaining the exemption. *See* NH App. 3688 (Heather Hahn et al.,

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[38] https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect.

Work Requirements in Social Safety Net Programs, Urb. Inst. 18 (Dec. 2017)).

In a similar vein, a recent nationwide report from the U.S. Department of Agriculture found that implementing work requirements for the Supplemental Nutrition Assistance Program (SNAP) was an "administrative nightmare" that was "error prone" in multiple states. NH App. 3315 (U.S. Dep't Agric., Off. Inspector Gen., *FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents* 5 (Sept. 29, 2016)). In several instances, the Department found that SNAP benefits were terminated even though the beneficiary qualified for an exemption. *Id.*

The State of Indiana provides yet another example of how the imposition of new systems and requirements can lead to unjust results. The State of Indiana upended its public assistance program systems and contracted with IBM to manage it. Indiana eventually sued IBM alleging breach of contract when IBM failed to implement the system properly. *See State v. Int'l Bus. Mach. Corp.*, 51 N.E. 3d 150 (Ind. 2016). IBM's failures included: incorrectly categorizing documents, inaccurate and incomplete data gathering of recipient and applicant information, failing to mail correspondence properly, not responding to or resolving help-ticket requests, and untimely processing of applications. *Id.* at 167. Despite individual beneficiaries' efforts to comply with state requirements, they were disenrolled due to the faulty administrative systems. *Id.* at 152–53, 157; *see* Virginia Eubanks, *Automating Inequality: How High-Tech Tools Profile, Police, and Punish the Poor* 43–44,

49–58 (2018) (Medicaid-eligible Indiana residents losing coverage due to state's system failures).

In the end, the programs' administrative burdens will deny Medicaid coverage to people who desperately need health care, even if they undertake herculean efforts to meet the programs' stringent requirements.

CONCLUSION

The Secretary of HHS's approvals of the Arkansas and New Hampshire waiver programs were arbitrary and capricious. If allowed to go forward, these programs would deliver a crushing blow to low-income adults in Arkansas and New Hampshire, leaving tens of thousands without health care coverage. As that result flouts the objectives of the Medicaid program, Amici respectfully request that this Court affirm the District of Columbia Circuit's judgments. In the alternative, Amici request that this Court grant the Federal Petitioners' motion to vacate the judgments below and remand with instructions that the approvals be remanded to HHS.

Respectfully submitted,

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