ORAL ARGUMENT NOT YET SCHEDULED

Case Nos. 19-5095 & 19-5097

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE DISTRICT OF COLUMBIA CIRCUIT**

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

v.

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

On Appeal from the United States District Court
for the District of Columbia
Case No. 1:18-cv-152

# BRIEF OF AARP, AARP FOUNDATION, JUSTICE IN AGING, NATIONAL ACADEMY OF ELDER LAW ATTORNEYS, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, AND THE AMERICAN LUNG ASSOCIATION AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS-APPELLEES URGING AFFIRMANCE

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## CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

All parties, intervenors, and amici appearing before the district court and this Court are listed in the Brief for Federal Appellants. All references to the rulings at issue appear in the Brief for Federal Appellants. These cases were not previously before this Court. Substantially similar issues appear in *Gresham v. Azar*, 19-5094, 19-5096 (D.C. Cir.), and *Philbrick v. Azar*, No. 1:19-cv-773 (D.D.C.) (Boasberg, J.).

Date: June 27, 2019

/s/ Maame Gyamfi
Maame Gyamfi

## CORPORATE DISCLOSURE STATEMENTS

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and D.C. Circuit Rule 26.1, Amici hereby submit the following disclosure statements:

**AARP and AARP Foundation**

The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) of the Internal Revenue Code and is exempt from income tax. The Internal Revenue Service has determined that AARP Foundation is organized and operated exclusively for charitable purposes pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. AARP and AARP Foundation are also organized and operated as nonprofit corporations under the District of Columbia Nonprofit Corporation Act.

Other legal entities related to AARP and AARP Foundation include AARP Services, Inc., and Legal Counsel for the Elderly. Neither AARP nor AARP Foundation has a parent corporation, nor has either issued shares or securities.

**Justice in Aging**

The Internal Revenue Service has determined that Justice in Aging is organized and operated exclusively for charitable purpose pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. Justice in Aging is also organized and operated as a non-profit corporation

pursuant to Title 29 of Chapter 6 of the District of Columbia Code (1951). It has no parent corporation, nor has it issued shares or securities.

**National Academy of Elder Law Attorneys**

The Internal Revenue Service has determined that the National Academy of Elder Law Attorneys is organized and operated exclusively as a business league, not organized for profit and no part of the net earnings of which inures to the benefit of any private shareholder or individual, pursuant to Section 501(c)(6) of the Internal Revenue Code and is exempt from income tax. The National Academy of Elder Law Attorneys is organized as a nonprofit corporation under the laws of Oregon. Another legal entity related to the National Academy of Elder Law Attorneys is the National Academy of Elder Law Attorneys Foundation. The National Academy of Elder Law Attorneys does not have a parent corporation and has not issued shares or securities.

**Disability Rights Education and Defense Fund**

The Disability Rights Education and Defense Fund (DREDF) is organized and operated as a non-profit, tax-exempt charitable organization pursuant to Section 501(c)(3) of the Internal Revenue Code. DREDF is also organized and operated as a non-profit corporation under California law. DREDF has no parent corporation or publicly held corporation that owns 10% or more of its stock. It has not issued shares or securities.

**The American Lung Association**

The American Lung Association is a not-for-profit corporation organized under the laws of the State of Maine and incorporated under Section 501(c)(3) of the Internal Revenue Code. The American Lung Association's mission is to save lives by improving lung health and preventing lung disease through education, advocacy and research. The American Lung Association has no parent companies, and no publicly held company has a 10% or greater ownership interest in the American Lung Association.

## STATEMENT REGARDING CONSENT TO FILE, SEPARATE BRIEFING, AUTHORSHIP, AND MONETARY CONTRIBUTIONS

All parties have consented to the filing of this brief. Amici Curiae certify that no party or party's counsel authored this brief in whole or in part, or contributed money intended to fund its preparation or submission. Amici Curiae also certify that only Amici Curiae provided funds to prepare and submit this brief. Fed. R. App. P. 29(c)(5).

Pursuant to D.C. Circuit Rule 29(d), Amici certify that a separate brief is necessary to provide the perspective of older adults and people with disabilities or chronic conditions and functional impairments, including a dedicated interest in having access to health care coverage.

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## GLOSSARY

| | |
|---|---|
| KAR | Kentucky Administrative Record |
| ACA | Patient Protection and Affordable Care Act |
| FPL | Federal Poverty Level |
| HHS | United States Department of Health and Human Services |
| NEMT | Non-Emergency Medical Transportation |
| NFIB | *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) |
| SNAP | Supplemental Nutrition Assistance Program |

## STATUTES AND REGULATIONS AT ISSUE

Pertinent statutes, regulations, and administrative materials are reproduced in the addendum or contained in the addendum of the Brief for Appellees.

## INTERESTS OF AMICI CURIAE

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 stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness. AARP and AARP Foundation advocate for access to quality and affordable health care across the country by, among other things, appearing as friend of the court on issues affecting older Americans. *See, e.g.*, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012); *Stewart v. Azar*, 366 F. Supp. 3d 125 (D.D.C. 2019).

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

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 Kentuckians who are affected by the Kentucky HEALTH waiver granted by the Department of Health and Human Services (Kentucky HEALTH), 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 American Lung Association is the nation's oldest voluntary health organization, representing the 35 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.

All Amici are national organizations affected by the Federal Appellants' approval of Kentucky HEALTH. At least fifteen other states have requested waivers involving work or "community engagement" requirements, and at least seven other states have requested waivers authorizing eligibility "lock-outs" for noncompliance.[1] This Court's ruling will have a nationwide impact on the extent to which low-income people have access to health care, and whether that health care will be subject to the types of restrictions established by Kentucky HEALTH.

Kentucky HEALTH applies to Medicaid coverage for Kentuckians ages 19 to 64 whose eligibility does not depend on meeting federal Medicaid law's definition of "disabled." (JA __) KAR 25510. As organizations that focus on the

[1] *See* Kaiser Family Foundation, *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* (current through June 13, 2019), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2.

interests of older Americans and persons with disabilities and chronic conditions, Amici have an interest in Kentucky HEALTH and in this litigation for two reasons. First, Kentucky HEALTH is likely to harm its citizens who have chronic conditions and functional impairments but are qualified for Medicaid as "disabled." Second, Amici have an interest in older persons and persons with disabilities, chronic conditions, and functional impairments who receive services in Medicaid programs outside Kentucky, and this Court's decision will affect the U.S. Department of Health and Human Services' (HHS) ability and willingness to grant similar waivers in other states. This Court's ruling will dramatically affect Medicaid beneficiaries across the country, regardless of the beneficiary's age, health status, and level of disability.

## INTRODUCTION

The district court correctly concluded that the Secretary of HHS violated the Administrative Procedure Act (APA) and the Medicaid statute when he approved Kentucky HEALTH under Section 1115 of the Social Security Act. Here, a crucial issue has been the true objectives of the Medicaid program. The most concise statement of these objectives, found at 42 U.S.C. § 1396-1, provides that Medicaid's core objective is to "furnish medical assistance" and "rehabilitation and other services" to low-income people.

As the district court found, the Secretary of HHS exceeded his authority in approving Kentucky HEALTH because the program does not promote furnishing medical assistance to low-income people. Instead, Kentucky HEALTH would terminate or at least reduce Medicaid coverage for tens of thousands of low-income Kentuckians ages 19 to 64.[2]

This loss of coverage would harm eligible beneficiaries, but would particularly devastate older adults and people with disabilities or chronic conditions. Appellants attempt to evade responsibility for this harm by characterizing the affected population as "able-bodied." *See* Fed. Br. 8, 10, 16, 34; Ky. Br. 1, 4, 25. In fact, the term "able-bodied" misrepresents these beneficiaries' needs and vulnerabilities as many "able-bodied" people have chronic conditions and need significant care.

Kentucky HEALTH harms low-income Kentuckians by tearing down significant coverage gains with new measures that siphon coverage. These measures include: (1) locking out beneficiaries from enrolling in Medicaid for up to six months if they fail to comply with the program's onerous new requirements, (2) ending the Medicaid protection that allows for coverage for certain pre-application months, and (3) ending non-emergency medical transportation.

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[2] The Federal Appellants assert that the waiver program does not affect the elderly. Fed. Br. 9-10. While Kentucky HEALTH's requirements do not affect people age 65 and over, they do impact people up to age 64.

Administrative errors will only serve to exacerbate the harm. Some beneficiaries already experienced these errors as they were preparing for Kentucky HEALTH. After-the-fact program evaluations and monitoring will not be enough to save these beneficiaries from losing their Medicaid coverage due to flaws in the waiver's design.

In the end, the challenged aspects of Kentucky HEALTH do nothing to improve or promote furnishing medical assistance to Kentucky's low-income population. Instead, they jeopardize these Kentuckians' access to coverage and care. As this result conflicts with Medicaid's objectives, the district court's decision should be affirmed.

## ARGUMENT

### I. Kentucky HEALTH Will Harm Vulnerable Kentuckians Who Depend on Medicaid For Their Health Care Coverage.

Kentucky HEALTH will lead to a substantial number of people being disenrolled from Medicaid because of their inability to comply with the requirements of the waiver. *Stewart v. Azar,* 366 F. Supp. 3d 125, 141 (D.D.C. 2019). In its application, Appellant Kentucky estimated the number to be around 95,000. (JA __) KAR 5419-23. Later, Appellants developed various explanations for what the 95,000 number represents and why the beneficiaries would no longer be in Medicaid. Fed. Br. 34; Ky. Br. 46-47. The bottom line, as the district court observed, is that the Secretary was obligated to adequately consider the significant

number of people who would lose coverage. *Stewart*, 366 F. Supp. at 140-143. He failed to do so, rendering the agency's approval arbitrary and capricious. *Id.* at 139, 145.

If anything, Appellant Kentucky's estimate understates the danger. Researchers recently used data from the Arkansas waiver to estimate potential losses that Kentucky HEALTH would cause. Leighton Ku & Erin Brantley, *Updated Estimates of the Effects of Medicaid Work Requirements in Kentucky*, GW Health Policy Matters, George Washington University (Revised Jan. 8, 2019). They estimate that Kentucky HEALTH would result in 26 to 41% of the age 19 to 64 Medicaid population losing coverage—86,000 to 136,000 persons. *Id.* This loss covers a one-year period, as opposed to the five-year period used in Appellant Kentucky's estimates. *Id*. Public commenters also warned of astronomical numbers of people who would lose coverage. (JA _) KAR 19194-205, 13437-40, 15482, 14654-58.

### A. Kentucky HEALTH's Punitive Six-Month Coverage Lock-Outs Harm Medicaid Beneficiaries And Impede Medicaid's Objectives.

The primary way that Kentucky HEALTH will cause people to lose their coverage is by locking out otherwise eligible Medicaid beneficiaries from Medicaid coverage because they fail to meet certain waiver provisions. (JA __) KAR 6756, 6759-60, 6770. These provisions are strikingly punitive. For a

transgression such as not timely submitting documentation, an otherwise eligible person could get locked out of Medicaid eligibility for up to six months.

Amici recognize that Appellant Kentucky legally may improve access to private health coverage or, under the proper circumstances, end eligibility for failure to submit required information as long as the beneficiary receives all due process protections. *See, e.g.*, 42 C.F.R. §§ 431.200-250 (right to notice and administrative hearing), 435.916 (redeterminations of eligibility). Medicaid law, however, does *not* allow for denying eligibility to otherwise eligible people, and thus imposing enrollment lock-outs is inconsistent with Medicaid objectives.

Under Kentucky HEALTH, the state can impose lock-outs in three situations: (1) when a beneficiary did not timely report changed circumstances, (2) when a beneficiary did not timely submit documentation for renewing eligibility, or (3) when a beneficiary did not pay a premium within 60 days of the due date. (JA __) KAR 6742. The premium-related lock-out applies only to those beneficiaries with incomes exceeding $1,040.83 monthly.[3] (Federal Poverty Levels (FPL) for 2019).

[3] The federal poverty level for 2019 is $12,490 annually, or $1,040.83 monthly. Thus, the maximum income for expansion Medicaid eligibility is $1,436.35 monthly (12,490 ÷ 12 X 138% = 1,436.10). *See* https://aspe.hhs.gov/poverty-guidelines.

Kentucky HEALTH provides some exceptions from coverage lock-outs for certain groups, such as pregnant women, former foster care youth, and "medically frail" beneficiaries. (JA__) KAR 6760. A beneficiary facing certain circumstances, including hospitalization, death of a family member, eviction, natural disasters, or domestic violence can also be exempt from lock-out. (JA __) KAR 6758. With these exemptions, however, comes the administrative burden of proving that one is eligible for the exemption.

A beneficiary subject to a lock-out can reenroll before the expiration of the lock-out period by paying required premiums and completing a re-enrollment education course on health or financial literacy. (JA__) KAR 6772-73. But this reenrollment right is only available once every twelve months. *Id.*

Kentucky HEALTH has multiple ways beneficiaries can lose coverage and many obstacles they must overcome to re-enroll. Appellant Kentucky based its lock-out request on inapt comparisons with private insurance. A stated Kentucky HEALTH program goal is to "encourage individuals to become active consumers of healthcare who are prepared to use commercial health insurance." (JA __) KAR 25520; Ky. Br. 46-47. To that end, Kentucky HEALTH was to "implement key commercial market and Marketplace policies in order to introduce these critical concepts to Kentucky HEALTH members." *Id*.

One such concept supposedly is the "client-specific open enrollment period:"

> … Specifically, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial market open enrollment deadlines, while also allowing members to rejoin the program at any time prior to the six-month date by completing a financial or health literary course.

(JA_) KAR 25512-13.

This reasoning, however, conflicts with the purpose of the Medicaid program. It also fails to recognize Medicaid beneficiaries' low-income reality. Medicaid exists precisely to provide health care coverage for persons who otherwise cannot afford private insurance coverage. Introducing coverage in Kentucky for the expansion population reduced the uninsured rate from 40.2% to 7.4%. (JA __) KAR 25505-506; *see also* KAR 20351 (Benjamin Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 Health Aff., 1119 app. tbl. 3 (2017)). Medicaid beneficiaries do not rely on Medicaid coverage because they are unfamiliar with private coverage. They do so because they cannot afford private coverage.

To defend imposing penalty lock-out periods, Appellant Kentucky also points to the Secretary's noting that interim evaluations from Indiana show that

modest premiums promote health and wellness. Ky. Br. 32. The data from Indiana does not support imposing lock-outs. Instead, the data reveals that 44% of Indiana Medicaid beneficiaries in the 100%-to-138% group were locked out of Medicaid *without* having alternative health care coverage. That deprivation of health care coverage violates Medicaid's clear objectives.

### B. Kentucky HEALTH's Roll-Back Of Recent Coverage Improvements Will Place Kentuckians with Chronic Conditions or Functional Impairments at Risk of Serious Harm.

Kentucky HEALTH will be a devastating set-back to health care coverage for low-income Kentuckians. Medicaid expansion in Kentucky has been a success story, with thousands of people gaining coverage. A recent study examining the impact of Medicaid expansion showed that in 2013, 40.2% of the low-income population was uninsured. (JA __) KAR 20351 (Sommers, *supra*). After the State expanded Medicaid, this percentage fell to 12.4%, 8.6%, and then 7.4% in 2014, 2015, and 2016, respectively. *Id.* Appellant Kentucky itself admits that many more Kentuckians than expected enrolled in Medicaid. Ky. Br. 3.

What is more, this increased level of insurance coverage led to health care improvements. Preventive care improved from 2013 to 2016 with increases of 26, 27, and 19% respectively in annual check-ups, annual cholesterol checks, and annual blood sugar checks. (Sommers, *supra*). The quality of care for persons with preexisting health care conditions showed similar improvement. High-risk

patients—those patients with histories of heart disease, stroke, diabetes, or hypertension—experienced an 11% increase in cholesterol checks. *Id.* People with chronic conditions were 13% more likely to receive regular care to address that condition. *Id*.

Simply put, Kentucky HEALTH represents a dramatic reversal of these substantial gains. Several eligible beneficiaries will suffer as a result of this regression, including: (1) expansion population beneficiaries in their 50s and 60s, (2) younger expansion population beneficiaries with chronic conditions or functional impairments, and (3) parent/caretakers with chronic conditions who are in the 50 to 64 age range in Kentucky's "traditional" Medicaid population and are not yet eligible for Medicare. In most cases, these people do not meet programmatic definitions of "disabled." *See* 42 U.S.C. § 1395c (listing Medicare eligibility standards). Yet these people are more likely to be facing significant health problems.

The 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 people ages 55 to 64 have at least two chronic conditions. (JA _) KAR 20658-59, 20662 (Steven Machlin et al., *Statistical Brief #203: Health Care Expenses for Adults with*

*Chronic Conditions* (May 2008)). Another 20.3% have one chronic condition, while only 22.7% have no chronic conditions. *Id.*

AARP came to similar conclusions in an analysis of data for people ages 50 to 64. (JA __) KAR 20503-504, 20508 (AARP Public Policy Institute, *Chronic Care: A Call to Action for Health Reform*, 11-12, 16 (March 2009)). It found that 72.5% have at least one chronic condition, and almost 20% experience some sort of mental illness. *Id.*

The National Institute on Aging and National Institutes of Health also reached similar results based on surveys of tens of thousands of respondents. Sixty percent of respondents between the ages of 55 and 64 reported at least one health problem, with 25% reporting at least two problems. (JA __) KAR 20383 (Nat'l Institute on Aging and Nat'l Institutes of Health, *Growing Older in America: The Health & Retirement Study* (March 2007)). For this study, a "problem" fit into one of six categories: hypertension, diabetes, cancer, bronchitis/emphysema, heart condition, and stroke. *Id*.

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. In 2016, for persons from ages 55 to

64, average annual health care expenses were 44% higher than for persons age 45 to 54, and 116% higher than for persons age 26 to 44.[4]

Finally, income also plays a role in health status, with lower-income persons experiencing more chronic conditions. In a study of people ages 50 and over with income below 200 percent of the FPL, 70% reported fair to poor health and/or at least one chronic condition. Sara Rosenbaum et al., *Medicaid Work Demonstrations: What Is at Stake for Older Adults?*, Commonwealth Fund (March 2018). Eighty-three percent reported fair to poor health and/or at least one chronic condition by age 55. *Id.* These percentages are at least 20 percentage points higher than the rates for persons with incomes exceeding 200 percent of the FPL. *Id.*

This data demonstrates how the restrictions that Kentucky HEALTH imposes on low-income beneficiaries in their 50s and 60s—along with some younger low-income beneficiaries with chronic conditions or functional impairments—will deprive them of much needed health care. Lost months of Medicaid coverage have a human cost: less preventive care, greater decline, and avoidable deterioration in physical and mental health.

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[4] Health Care Cost Institute, *2016 Health Care Cost and Utilization Report Appendix*, at 1 (Table A1) (Jan. 2018), https://www.healthcostinstitute.org/images/pdfs/2016-HCCUR-Appendix-1.23.18-c.pdf. Annual health care expenses for the 55 to 64 population, the 45 to 54 population, and the 26 to 44 population were $10,137, $7,026, and $4,695, respectively. (10,137 ÷ 7,026 = 144%; 10,137 ÷ 4,695 = 216%).

The lost coverage will also have a cost to the national economy through Medicare. People who did not have health insurance before getting on Medicare at age 65 are sicker and more expensive to cover than if they had access to adequate preventative care throughout adulthood. *See* U.S. Gov't Accountability Off., GAO-14-53, *Medicare: Continuous Insurance Before Enrollment Associated With Better Health and Lower Program Spending,* 9 (Dec. 2013)[GAO study][5] (finding that the previously uninsured had 35% more Medicare spending in the first year of enrollment than those insured continuously for six years).

### C. Appellants' Characterizing the Kentucky HEALTH Population As "Able-Bodied" Misrepresents This Population's Health-Related Challenges And The Harm The Program Will Cause Them.

Kentucky HEALTH affects five separate Medicaid eligibility groups: parents and other caretaker relatives, pregnant women, former foster care youth, transitional medical assistance, and the "new adult group." (JA _) KAR 6754. This "new" group is the population of adults (ages 19 to 64) who gained eligibility through the Affordable Care Act's (ACA) expansion of Medicaid eligibility, and by Appellant Kentucky's later decision to offer coverage to this group. (JA __)

[5] https://www.gao.gov/assets/660/659753.pdf.

KAR 25510; *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); Pub. L. No. 111-148, § 2001 (2010) (ACA provision).

Appellants have characterized the Kentucky HEALTH population as "able-bodied."[6] *See* Fed. Br. 10, 16, 34; Ky. Br. 1, 4, 25. But the term "able-bodied" hides many harms that likely would result if the state implements Kentucky HEALTH. Although Medicaid eligibility rules may classify a person as "disabled" or "not disabled," disability in real life is a continuum. A Medicaid beneficiary may not be formally "disabled" under Medicaid law, but still face significant health-related challenges.

For example, data from the National Center for Health Statistics shows that about 40% of working-age Medicaid beneficiaries "have broadly defined disabilities, most of whom are not readily identified as such through administrative records." (JA __) KAR 20310 (H. Stephen Kaye, *How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements?*, Community Living Policy Ctr. 2 (Feb. 2018)).

Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Kentucky's non-elderly Medicaid population who are not receiving Supplemental Security Income due to

[6] "Able Bodied" is not a term used in federal Medicaid law, which classifies people as disabled or "not disabled."

disability, 51% cited being ill or disabled as the reason for not being employed. (JA _) KAR 25928 (Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work*, at 10 (App. tbl. 2), Kaiser Family Foundation, (Jan. 2018)).

Other data sources agree that many people suffer from serious health conditions even if they are not considered "disabled" under the Medicaid definition. Among Medicaid beneficiaries not classified as aged or disabled, 52% reported serious difficulty with mobility. (JA _) KAR 26298 (MaryBeth Musumeci et al., *How Might Medicaid Adults with Disabilities Be Affected by Work Requirements in Section 1115 Waiver Programs?*, Kaiser Family Foundation, (Jan. 2018)); *see also* (JA _) KAR 25818-19 (Rachel Garfield et al., *Implications of Work Requirements in Medicaid: What Does the Data Say?*, Kaiser Family Foundation (June 2018)) (prevalence of chronic conditions among non-working Medicaid beneficiaries). Fifty-one percent noted serious difficulty with cognitive functioning. *Id.* Forty-two percent experienced serious difficulty with independent living tasks (e.g., shopping). *Id.* Another 21% reported serious difficulty with daily living activities such as dressing or bathing. *Id.*

Medicaid law classifies a beneficiary as either "aged" (age 65 or older) or not. *See, e.g.*, 42 U.S.C. § 1396d(a). 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." Thus, Appellants' use of the term "able-bodied" hides the many challenges facing this population.

## II. Waiving Retroactive Coverage Harms Medicaid Beneficiaries And Impedes Medicaid's Objectives.

### A. Permitting Coverage Before The Month The Beneficiary Applies for Medicaid Protects Low-Income People Who Have Suffered An Unforeseen Injury or Health Setback.

Appellant Kentucky requested and the Federal Appellants approved the waiver of an important patient protection that allows Medicaid coverage to begin up to three months before the application month, provided the applicant was eligible during that period. (JA __) KAR 6741, 6748 & 6756. The Secretary has similarly waived pre-application coverage for seven other states. These waivers apply to the Medicaid expansion population in Arkansas, Indiana, and New Hampshire; to a non-expansion Medicaid population in Florida; and to both the expansion population and a non-expansion population in Arizona, Iowa, and New Mexico. *See Medicaid Waiver Tracker*, *supra* at 3 n.2.

Waiver of pre-application coverage dangerously impedes Medicaid objectives by denying coverage for persons who cannot afford out-of-pocket expenses or private health insurance. In 1973, Congress enacted 42 U.S.C. § 1396a(a)(34), which requires a state Medicaid program to provide coverage for up to three months before the application month, as long as the person met eligibility requirements during those months. Before then, states had the *option* of

offering that coverage, and 31 states in fact did so. S. Rep. No. 92-1230, at 209 (1972) (contained within Vol. 3 of Amendments to The Social Security Act 1969-1972, p. 221 of 1273).

In recommending that all states provide this coverage, a Senate committee report noted that the amendment would "protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying." *Id.*; *see also Cohen ex rel. Cohen v. Quern*, 608 F. Supp. 1324, 1332 (N.D. Ill. 1984) (quoting from Senate report).

This accommodation makes good sense. In states that did not offer coverage before the month of application, injured persons often could not receive needed health care. The Secretary of Health, Education, and Welfare explained the problem in testimony supporting the legislative amendment:

> Providers have been reluctant in many instances to care for potential Medicaid eligibles because frequently the patient has not applied for Medicaid prior to his illness and, therefore, the providers would not be eligible to receive payment for their services.

Statement by Elliot L. Richardson, Sec'y of HEW, before the Sen. Fin. Comm., at 11 (July 14, 1970) (contained within Vol. 8 of Amendments to The Social Security Act 1969-1972, p. 1262 of 1267). This problem is no less vexing today, as lack of

health care coverage continues to limit low-income people's access to needed health care.

Today, sections 1396a(a)(34) and 1396d(a) establish the right to pre-application coverage. Congress has rejected recent legislative efforts to amend sections 1396a and 1396d to eliminate this protection. H.R. 1628, 115th Cong. § 114(b) (2017); H.R. 180, 115th Cong. § 1 (2017); H.R. 5626, 114th Cong. § 1 (2016); S. Amend.270 to S. Amend.267, 115th Cong., Tit. I of Better Care Reconciliation Act of 2017, § 127(a) (2017) (within 163 Cong. Rec. S4196, S4205 (July 25, 2017)). This failed legislation supports Appellees' argument that Appellants, in approving Kentucky HEALTH, have inappropriately taken over a legislative function to fundamentally transform Medicaid. *See* Appellees Br. 1, 4.

### B. Due to Injury or Unfamiliarity with the Health Care System, Low-Income People Often Do Not Apply for Medicaid Coverage Within the First Month They Receive Care.

Amici routinely witness the importance of retroactive Medicaid coverage. Many hospitalizations are unplanned. Our members, clients, and patients suffer strokes, auto accidents, and falls, among other setbacks. They unexpectedly find themselves in hospitals and nursing facilities, often struggling with terrifying new medical realities. It is little surprise that many do not file a Medicaid application

within the initial month, particularly when the "month" of admission may just be a day or two before one month turns into another.

Under Kentucky HEALTH, a woman who has an accident with an uninsured driver on January 30th could be liable for thousands of dollars of hospital expenses due to the "failure" to file a Medicaid application within 36 hours, when January becomes February. This could result in thousands of dollars of health care costs. A comparable fact pattern was present in a Sixth Circuit decision involving Section 1396a(a)(34). *Schott v. Olszewski*, 401 F.3d 682 (6th Cir. 2005). There, an emergency hospitalization led to pre-Medicaid-application health care bills totaling approximately $50,000. *Id*. at 685.

### C. Medicaid Beneficiaries By Definition Cannot Afford Private Insurance, So Medicaid Policies Regarding Coverage Effective Dates Should Not Be Based on Private Insurance Practices.

In its application, Appellant Kentucky justifies waiver of pre-application coverage by making comparisons to private insurance, which generally does not become effective until the applicant pays the relevant premium. It claims that "[e]liminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when the individual is healthy." (JA _) KAR 25521; *see also* Ky. Br. 13, 32, 40. It also asserts that this elimination is "consistent with the commercial market and federal Marketplace policies." (JA _) KAR 25521.

The flaws of Appellant Kentucky's claims are in the premises that underlie them—that Medicaid beneficiaries can afford private insurance, and that Medicaid should emulate private insurance policies. But people are eligible for Medicaid precisely because they cannot afford private health insurance. Limiting Medicaid coverage does not incentivize purchase of private health insurance. Instead, it leads inexorably to more uninsured persons, deficient health care, and unpaid health care bills. Kentucky's high rate of uninsured persons before the Medicaid expansion shows this fate.

What is more, Medicaid should not and cannot be administered like private insurance. Medicaid coverage is based on financial need, not on payment of premiums. The federal Medicaid statute prohibits premiums or, for people with incomes above 150% of the FPL, caps total cost sharing at 5% of income. 42 U.S.C. §§ 1396o(c)(1), 1396o-1(b)(1)-(2). Appellant Kentucky, therefore, has no pro-health-care policy reason to deny Medicaid coverage for care received within three months of application. After all, retroactive coverage is only available during months in which the person is financially eligible. 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915(a)(2).

Imagine that a patient who suffered an unexpected severe injury in February applies for Medicaid coverage in May. If his low-income financial situation met

the eligibility standards for the preceding February and all subsequent months, a safety-net health care program should authorize coverage starting in February.

Put another way, eliminating pre-application coverage for February, March, and April would frustrate Medicaid's objectives. Without retroactive coverage, the patient may not seek care when he first needs it because he cannot afford it. Or if he receives care, he could face unaffordable bills. A health care provider who provided him care in February would suffer a loss, with no way to receive reimbursement for services provided. This would lead providers to not provide care for low-income people in need unless the person can first prove that they already have Medicaid coverage.

Appellant Kentucky claims that it wants to encourage Medicaid enrollment when persons are healthy, but its efforts to emulate private coverage are wrongheaded. Medicaid works for its low-income population by, among other protections, mandating retroactive coverage. By changing this feature, Appellant Kentucky will not move Medicaid beneficiaries into private insurance. Instead, it will make it more likely that low-income Kentuckians will be denied care or saddled with unaffordable bills. In turn, this will push private insurance even more out of reach.

### III. Waiving Non-Emergency Medical Transportation Harms Beneficiaries And Impedes Medicaid's Objectives.

Kentucky HEALTH waives the requirement that the Medicaid program ensure necessary transportation to and from health care services. Under federal law, "necessary" transportation can include both emergency and non-emergency transportation. 42 C.F.R. § 431.53. Kentucky HEALTH ends non-emergency medical transportation (NEMT) for persons in the Medicaid expansion population. It also ends non-emergency transportation for methadone treatment services for nearly all Medicaid beneficiaries, including those deemed "medically frail." However, pregnant women, "medically frail" beneficiaries (other than for methadone treatment), or any persons eligible for Medicaid before the ACA retain the NEMT program. (JA__) KAR 6762-63.

Many low-income people simply cannot afford to buy a car or hire a transportation service. Some lack access to affordable and reliable public transit. These issues—particularly when compounded by physical accessibility barriers—make the NEMT benefit especially critical for persons with chronic conditions or functional impairments. In that regard, the Government Accountability Office (GAO) found that "excluding the NEMT benefit would impede . . . enrollees' ability to access health care services, particularly individuals living in rural or underserved areas, as well as those with chronic health conditions." (JA __) KAR 20484 (U.S. Gov't Accountability Off., GAO-16-221, *Medicaid: Efforts to*

*Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage* (Jan. 2016)).

To support ending the program, Appellant Kentucky relies in part on data showing that, from June 2014 through June 2015, the Kentucky "expansion" population of more than 400,000 beneficiaries used fewer than 140,000 non-emergency trips. (JA __) KAR 25546. But this data does nothing to justify Appellant Kentucky's position. On the contrary, the data show that with Kentucky HEALTH, there may be around 140,000 instances annually where a low-income Kentuckian will not be able to obtain needed transportation to a health care appointment. Most instances will involve a person with a chronic condition or functional impairment. For these reasons, Kentucky HEALTH's ending NEMT conflicts with Medicaid's objectives.

## IV. Foreseeable Administrative Errors Will Magnify Kentucky HEALTH's Unfairness and Harm.

As discussed above, Kentucky HEALTH imposes significant and unfair obligations on low-income Kentuckians, with the evident intent to reduce Medicaid enrollment. Predictable administrative errors and bottlenecks will only exacerbate the harm. "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 and Policy Priorities, *Taking Away Medicaid for Not*

*Meeting Work Requirements Harms Older Americans* 2 (Dec. 5, 2018), https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-older-americans.

Kentucky HEALTH shifts administrative obligations to beneficiaries. As a result, beneficiaries are more likely to lose coverage inappropriately. For example, under the work requirements, beneficiaries must report at least 80 hours of work or other "community engagement" per month. (JA_) KAR 6775. A beneficiary can be disqualified by misunderstanding what constitutes a qualifying activity or failing to provide adequate documentation under the strict deadlines. Jennifer Wagner & Judith Solomon, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries*, Ctr. on Budget and Policy Priorities, 6 (May 23, 2018), https://www.cbpp.org/sites/default/files/atoms/files/5-23-18health2.pdf.

Another example involves the "medically frail" exemption to Kentucky HEALTH's work requirements. The qualifications for medically frailty have already generated significant confusion. Deborah Yetter, *"It's a mess": Kentucky Medicaid Unclear on "Medically Fragile" Meaning*, Louisville Courier Journal (Dec. 6, 2018), https://www.courier-journal.com/story/news/2018/12/06/ kentucky-medicaids-medically-fragile-meaning-unclear/2217346002/. Some people were not qualifying as "medically frail" despite having a serious and complex medical

condition. *Id.* Other people were not qualifying despite other people with similar conditions qualifying for the status. *Id.* Some distinctions seemed arbitrary. One psychiatric health center reported that 28 out of 44 applications for "medically fragile" status were denied despite all 44 patients having generally similar circumstances. *Id*.

In a similar vein, a 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 several states. (JA_) KAR 20634 (U.S. Dep't of Agric., Office of the Inspector Gen., *FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents*, 5 (Sept. 29, 2016)). In several instances, the Department found that the state terminated SNAP benefits even though the beneficiary qualified for an exemption. *Id*.

Predictably, massive new administrative systems combined with new documentation and reporting requirements results in the improper disenrollment of public benefit beneficiaries. The State of Indiana provides one example. 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. IBM's failures included: (1) incorrectly categorizing documents, (2) inaccurate and incomplete data gathering of recipient

and applicant information, (3) failing to mail correspondence properly, (4) not responding to or resolving help-ticket requests, and (5) untimely application processing times. *State v. IBM*, 51 N.E. 3d 150, 156 (Ind. 2016).

Despite individual beneficiaries' efforts to comply with state requirements, the faulty administrative systems caused them to be disenrolled. *Id.* at 157; *see* Virginia Eubanks, *Automating Inequality: How High-Tech Tools Profile, Police, and Punish the Poor*, 43-44, 49-58 (2018 St. Martin's Press New York) (Medicaid-eligible Indiana residents losing coverage due to state's system failures).

It is foreseeable that eligible Kentuckians will experience similar administrative barriers to coverage based on the state's new waiver processes and systems. As a result, thousands of citizens who depend on Medicaid will fall through the cracks and lose their access to care.

## V. After-the-Fact Monitoring or Threats to Terminate Medicaid For People Ages 19 to 64 Cannot Justify Approving Kentucky HEALTH.

Monitoring and evaluation activities attached to Kentucky HEALTH will not remedy the inappropriateness of the proposed requirements and limitations. (JA_) KAR 6723, 6728, 6793-97. After all, after-the-fact program evaluations will not improve the dangers for low-income people and people with disabilities who improperly lose coverage.

Appellants also argue that, if Appellant Kentucky cannot implement Kentucky HEALTH, it will eliminate coverage for the Medicaid expansion population. Fed. Br. 4-6, Ky. Br. 35-38. This threat is effectively holding the expansion population hostage to modify the state's Medicaid program in a way contrary to Medicaid's objectives. Even if the state believes the Medicaid expansion program is optional, it still cannot disregard Medicaid law when developing its plan. *See, e.g.*, *Doe v. Chiles*, 136 F.3d 709, 714 (11th Cir. 1998); *NB* ex rel. *Peacock v. District of Columbia*, 794 F.3d 31, 35 (D.D.C. 2015).

Even if financial distress could justify granting an otherwise inappropriate waiver, Appellants have not adequately explained the supposed budgetary difficulties or why the expansion population should be on the chopping block. The federal government covers 90% of the expansion population expense, but only 71.82% of expenses generally for Kentucky's adult Medicaid beneficiaries. 42 U.S.C. § 1396d(y)(1)(E) (90% federal financial participation (FFP) for expansion population); 83 Fed. Reg. 61157, 61159 (Nov. 28, 2018) (71.82% FFP for Kentucky); *see Stewart*, 313 F. Supp. 3d at 271.

The Kentucky government has not persuaded its citizens on the merits of Kentucky HEALTH either. Roughly two-thirds of Kentuckians oppose attempts to scale back Medicaid or to end current coverage of non-emergency medical transportation, along with dental and vision care. Mason-Dixon Kentucky Poll

(Dec. 2018), https://files.constantcontact.com/b5743304701/b0e1f2b2-fa47-4da7-8f53-c9223c5453b3.pdf; Joe Sonka, *Poll: Majority of Kentuckians oppose scaling back Medicaid program*, Insider Louisville (Jan. 9, 2019), https://insiderlouisville.com/government/poll-majority-of-kentuckians-oppose-scaling-back-medicaid-program/.

## CONCLUSION

The Federal Appellants exceeded their authority in approving Kentucky HEALTH. The State's Section 1115 waiver would deliver a crushing blow to low-income Kentuckians, leaving tens of thousands without health care coverage. As that result flouts the objectives of the Medicaid program, this Court should affirm the district court's decision.

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Respectfully submitted,

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**CERTIFICATE OF COMPLIANCE WITH RULE 32(A)**

1. This brief complies with the type-volume limitation of FED. R. APP. P. 32(a)(7) and Circuit Rule 32(a)(2) because: this brief contains 6,119 words, (excluding the parts of the brief exempted by FED. R. APP. P. 32(a)(7)(B)(iii)) as determined by the word counting feature of Microsoft Office Word 2016).

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Dated: June 27, 2019

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## CERTIFICATE OF SERVICE

I hereby certify that on June 27, 2019, I electronically filed the foregoing Brief of AARP, AARP Foundation, Justice In Aging, National Academy of Elder Law Attorneys, Disability Rights Education and Defense Fund, and the American Lung Association As Amici Curiae In Support Of Plaintiffs-Appellees with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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