Nos. 20-37 & 20-38

IN THE
Supreme Court of the United States

NORRIS COCHRAN, ACTING SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

AND

STATE OF ARKANSAS,
Petitioners,

v.

CHARLES GRESHAM, ET AL.,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF OF LEUKEMIA & LYMPHOMA SOCIETY, CROHN'S & COLITIS FOUNDATION, AND NATIONAL ORGANIZATION FOR RARE DISORDERS AS *AMICI CURIAE* IN SUPPORT OF PRIVATE RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amicus Leukemia and Lymphoma Society is a 501(c)(3) charitable organization whose mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma and to improve the quality of life for the more than 1.3 million people in the United States living with blood cancer.

Amicus Crohn's & Colitis Foundation is dedicated to finding the cures for Crohn's disease and ulcerative colitis and to improving the quality of life of children and adults affected by these diseases, collectively known as inflammatory bowel disease ("IBD"). Treatment for the as many as 3.1 million Americans who are affected by IBD is highly individualized, and studies show that better health outcomes are associated with consistent and timely access to care. Further, IBD treatments are expensive, and most Americans with IBD cannot afford their care without insurance coverage.

Amicus National Organization for Rare Disorders ("NORD"), a 501(c)(3) organization, is a patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them. NORD, along with its more than 300 patient organization members, is committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici* or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), counsel for *amici* also represent that all parties have consented to the filing of this brief.

Amici represent millions of Americans living with serious and chronic health conditions. *Amici*'s common aim is to ensure affordable, accessible, and adequate coverage for patients, including those who rely on Medicaid. *Amici* each participated in the approval processes for one or more work-requirement waivers approved by the Secretary of Health and Human Services ("HHS").

INTRODUCTION

Medicaid provides access to health care coverage for nearly 70 million Americans. The purpose of Medicaid is to enable States to provide "medical assistance" and "rehabilitation and other services" to families with dependent children and to "aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. In 2010, the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") expanded Medicaid by adding adults earning up to 133% of the federal poverty line to the groups eligible for coverage. *Id.* § 1396a(a)(10)(A)(i)(VIII). It is optional for States to cover this expansion population. *See NFIB v. Sebelius*, 567 U.S. 519, 587 (2012) (plurality).

To further the objective of providing coverage to these groups, Medicaid imposes certain minimum requirements on States that accept program funding. *See* 42 U.S.C. § 1396a. The Secretary of HHS may grant a waiver of these requirements to allow States to implement pilot or demonstration projects, but only if the Secretary finds that the projects are "likely to assist in promoting the objectives" of the Medicaid program. *Id.* § 1315(a) (Social Security Act § 1115(a)).

In 2018, Arkansas and New Hampshire were among several States that requested a waiver to permit them to impose "work and community-

engagement requirements" on Medicaid beneficiaries. *See* App. 4a-5a, 70a-71a.[2] The proposed work requirements imposed onerous new burdens on enrollees, including reporting requirements with monthly submissions of complicated, variable information.

In response to these waiver requests, *amici* and other organizations representing millions of Medicaid beneficiaries submitted comments and letters to the Secretary, the Centers for Medicare & Medicaid Services ("CMS"), and state agencies that administer Medicaid programs.[3]

For instance, in May 2018, two of the *amici* and other patient organizations wrote to the CMS Administrator, warning that "work requirements will likely result in patients and consumers losing access to the care they need to manage their condition(s) or inappropriately forcing beneficiaries into work situations that may worsen their health in order to maintain coverage." CAN Letter at 3. Similarly, in an August 2018 letter to the Secretary regarding New Hampshire's waiver, two of the *amici* and other organizations reiterated their concerns, citing emerging evidence from Arkansas that reporting requirements caused a decrease in coverage. *See* ACHA Letter at

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[2] Except where otherwise noted, references to "App." are to the appendix accompanying the certiorari petition filed by the federal petitioners in No. 20-37.

[3] *See*, *e.g.*, Letter from Adult Congenital Heart Ass'n et al. to Alex Azar, Secretary, U.S. Dep't of Health & Human Servs. (Aug. 31, 2018) ("ACHA Letter"), https://www.marchofdimes.org/08-31-18%20Health%20Partner%20Comments%20New%20Hampshire%20Wai.pdf; Letter from American Cancer Ass'n Cancer Action Network et al. to Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Servs. (May 14, 2018) ("CAN Letter"), http://www.heart.org/idc/groups/ahaecc-public/@wcm/@adv/documents/downloadable/ucm_501216.pdf.

2-3. In these letters, *amici* presented evidence that work requirements create administrative burdens that reduce access to health care coverage, do not result in increased employment, and can have adverse consequences for beneficiaries' health.

But, despite this evidence, the Secretary approved the Arkansas and New Hampshire waiver requests. In so doing, he did not address the concerns that *amici* and other commenters raised, nor did he explain how imposing work requirements will lead to increased access to health care coverage.

Following challenges by Medicaid beneficiaries in Arkansas and New Hampshire, the district court held, and the D.C. Circuit affirmed, that the Secretary's decision-making was arbitrary and capricious. *See* App. 1a-2a, 20a-22a.

The D.C. Circuit held that the "principal objective of Medicaid is providing health care coverage," App. 9a-10a, citing Medicaid's appropriations provision, 42 U.S.C. § 1396-1; the Medicaid statute's detailed definition of "medical assistance," *id.* § 1396d(a); and the decisions of five other circuits concerning Medicaid's core purpose.[4] Because a demonstration project must be "likely to assist in promoting the objectives" of Medicaid to receive a waiver, *id.* § 1315(a), and because providing health care coverage is Medicaid's primary objective, the Secretary was obligated to address the concern that coverage

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[4] *See Price v. Medicaid Dir.*, 838 F.3d 739, 742 (6th Cir. 2016); *Virginia ex rel. Hunter Labs., L.L.C. v. Virginia*, 828 F.3d 281, 283 (4th Cir. 2016); *University of Washington Med. Ctr. v. Sebelius*, 634 F.3d 1029, 1031, 1034-35 (9th Cir. 2011); *Pharmaceutical Res. & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001), *aff'd*, 538 U.S. 644 (2003); *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991).

loss would result from work requirements. *See* App. 12a-18a. He failed to do so, "dismiss[ing] those concerns in a handful of conclusory sentences." App. 17a. The court held that "[n]odding to concerns" about coverage loss "only to dismiss them in a conclusory manner is not a hallmark of [the] reasoned decisionmaking" required of federal agencies. *Id.* The court therefore concluded that the Secretary's failure to consider an "important aspect" of the problem, *Motor Vehicle Mfrs. Ass'n of United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), rendered the approval of the waivers arbitrary and capricious. App. 16a-17a.

SUMMARY OF ARGUMENT

The D.C. Circuit correctly identified Medicaid's primary objective – to enable States to provide coverage to those who cannot afford it. Its judgments should be affirmed on this ground alone. But even if Medicaid has other objectives, like promoting better health outcomes, the Secretary's approvals still were arbitrary and capricious.

I. As *amici* explained in their comments, work requirements impose administrative burdens that undermine enrollment and retention, even for those who satisfy the requirements or should receive an exemption. Research on Medicaid and similar programs long has established the harmful effect of administrative burdens on enrollment, which has led Congress and CMS to adopt administrative simplification measures. The Secretary's failure to consider the risk of coverage loss reflects a disregard of that extensive research and those congressional policy judgments.

Beyond the administrative burdens of complying with work requirements' complex reporting obligations, beneficiaries often are unaware of whether or

how work requirements apply to them. For those without regular Internet access or permanent housing, state outreach efforts about these requirements are frequently ineffective. Even if beneficiaries are aware of the requirements, a lack of consistently available work hours, high rates of turnover, and seasonality in low-wage jobs can result in coverage losses.

Moreover, evidence suggests that work requirements are unlikely to result in either increased health care coverage or increased employment. Medicaid beneficiaries who can work already do. Those beneficiaries who lose Medicaid coverage as a result of work requirements are unlikely to gain it elsewhere, because few are able to afford private insurance and because low-wage employers seldom provide coverage. The consequence is a significant disruption to care, just as the academic research and comments presented to the Secretary predicted.

The short-lived implementation of work requirements in Arkansas largely confirmed the evidence and research the commenters put forth. The Secretary nevertheless disregarded that evidence when he approved New Hampshire's waiver, compounding the capriciousness of his decision.

II. In addition to ignoring the evidence *amici* and others presented about the ineffectiveness of work requirements, the Secretary's Arkansas approval letter cited research purportedly indicating that work requirements improve health and wellness. Arkansas contends that the Secretary's prediction that work requirements would promote beneficiary health and independence was reasonable.

But the research cited by the Secretary in the Arkansas approval letter does not support this contention. The research came largely from countries

with universal health coverage, so they are mostly not germane to a policy that principally threatens beneficiaries' health by rendering them uninsured. To the extent the research the Secretary relied upon can be considered relevant, it contained warnings – disregarded by the Secretary – about the harmful health effects of forcing people off benefits and into low-quality work.

Finally, the Secretary's approvals cannot be rationalized as an effort to fill a gap in the social science literature. Arkansas did not propose a meaningful evaluation plan in its application and did not timely finalize its evaluation design.

ARGUMENT

I. THE SECRETARY IGNORED ROBUST EVIDENCE THAT WORK REQUIREMENTS WOULD NEITHER INCREASE COVERAGE NOR IMPROVE HEALTH OUTCOMES

Amici consistently have opposed work requirements because evidence shows that such requirements can undermine Medicaid enrollment and retention. Because Medicaid beneficiaries who lose coverage are unlikely to obtain coverage elsewhere, the consequence of work requirements for thousands of Medicaid enrollees is an overall decrease in health care coverage and potentially life-threatening disruptions to care.

Based on existing research at the time of the Secretary's approvals, it was foreseeable that work requirements likely would cause substantial coverage losses without contributing positively to overall employment. The Secretary disregarded this research. And, in approving New Hampshire's waiver request, the Secretary also failed to consider the troubling evidence of disenrollments that emerged from Arkan-

sas's short-lived implementation of the work requirements. These failures to consider the foreseeable and evident harms of work requirements rendered the Secretary's decisions arbitrary and capricious.

A. Administrative Burdens Undermine Enrollment And Retention

In the Secretary's Arkansas approval letter, he purported to consider the health risks to those who failed to comply with the new work requirements, but he made no effort to address the loss of coverage *amici* and others warned would result from the imposition of the requirements. App. 140a. In the Secretary's New Hampshire approval letter, he wrote that "it is not possible to know in advance the actual impact that its policies will have on enrollment." App. 165a. Arkansas agrees, suggesting that it was not possible for the Secretary to anticipate the coverage losses that Arkansas's work requirements would cause. Ark. Br. 50.[5]

But, by the time of the Secretary's approvals, an extensive body of research – oftentimes funded or performed by components of HHS – had established that such requirements have significant effects on Medicaid enrollment and retention. Similar conclusions also emerged from studies of the Children's Health Insurance Program ("CHIP"), an analogous means-tested federal-state program for providing health coverage to the needy. Congress's enactment of enrollment-simplification measures for CHIP in 2009 and Medicaid in 2010 reflects its recognition of this research. The Secretary's failure to consider the effects of the onerous new reporting requirements

[5] New Hampshire does not try to defend the Secretary's failure to consider the coverage losses that the work requirements would cause.

under the Arkansas and New Hampshire waivers therefore reflected a disregard of extensive research and congressional policy judgments.

1. Studies of Medicaid long have demonstrated that administrative burdens are a principal cause of low enrollment and retention. A review of the literature in 2012 by the Office of the Assistant Secretary for Planning and Evaluation ("ASPE") within HHS found that only 50-70% of adults eligible for Medicaid nationwide actually were enrolled. *See* Ben Sommers et al., *Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act*, ASPE Issue Brief (Mar. 16, 2012). By contrast, programs with more-universal eligibility and simpler enrollment processes, like Social Security, have participation rates near 100%. *See* Pamela Herd & Donald P. Moynihan, *Administrative Burden: Policymaking by Other Means* 6 (2018) ("Herd & Moynihan, *Administrative Burden*").

Adult enrollment in Medicaid has been not only low overall but also "highly unstable over time." Benjamin D. Sommers, *Loss of Health Insurance Among Non-elderly Adults in Medicaid*, 24 J. Gen. Internal Med. 1, 6 (Jan. 2009). This 2009 study estimated that, among all adults enrolled in Medicaid, 21.4% were not enrolled a year later. *Id.* at 2. This was not principally because they lost eligibility or got other insurance; indeed, half remained uninsured. Rather, it was because of "bureaucratic obstacles," for which "simplifying the Medicaid renewal process" was the appropriate solution. *Id.* at 4, 6.

Another 2009 study likewise attributed Medicaid coverage loss to "antiquated" and "unnecessarily complicated renewal procedures," like frequent recertification and income-documentation requirements.

Leighton Ku et al., *Improving Medicaid's Continuity of Coverage and Quality of Care*, Ass'n for Cmty. Affiliated Plans, at 7 (July 2009). The study estimated that the average person enrolled in Medicaid was covered for only 78% of the year. This level varied widely by population type. Children and the disabled, who benefitted from simpler enrollment and renewal procedures, had much higher continuity than adults. *Id.* at 7-8.

2. State policy changes furnish ample evidence of the effect of administrative burdens on enrollment. For instance, in 2003, the State of Washington began requiring documentation of income, and it required renewal – entailing recertification of eligibility – every six months instead of every 12. *See* Tricia Brooks, *Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP*, Georgetown Univ. Health Pol'y Inst., at 2 (Jan. 2009). Enrollment soon dropped by more than 30,000. In 2005, Washington reverted to a 12-month renewal policy. With that and other simplification measures, enrollment quickly rebounded to its pre-2003 level. *Id.*

In 2001, Louisiana introduced "ex parte" renewals for children on Medicaid, in an effort to simplify the renewal process and reduce coverage loss. *See* Laura Summer & Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*, The Commonwealth Fund, at 19-20 (June 2006). Louisiana began using administrative data from its Supplemental Nutrition Assistance Program ("SNAP") to recertify Medicaid beneficiaries' eligibility, freeing families of the obligation to supply new documentation. *Id.* By 2005, successful renewals increased from 72% to 92%. *Id.* at 20.

In 2004, Wisconsin began requiring Medicaid applicants to verify their income and health insurance status at enrollment and renewal. *See* Herd & Moynihan, *Administrative Burden* at 176. Applicants had to provide information from other members of their households and from their employers. *Id.* Eight months after the requirements went into effect, enrollment had fallen by 23%. *Id.* Importantly, the new requirements largely harmed the eligible. They either could not procure the required information or did not understand what was now required of them. *Id.*

3. Federal policy changes likewise demonstrate the effect of administrative burdens on Medicaid enrollment. In 2005, Congress required Medicaid applicants to submit documents proving their citizenship. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6036, 120 Stat. 4, 80-81 (2006), codified at 42 U.S.C. § 1396b(x) (2006). Medicaid already required enrollees to be citizens but had permitted applicants to declare their citizenship under penalty of perjury. *See* 42 U.S.C. § 1320b-7(b), (d) (2000). Under the new law, applicants were required to submit passports or certain other documentation specified by statute.

The effects of the new proof-of-citizenship requirement were soon evident. An early review of seven States found significant drops in enrollment that state officials attributed "primarily or entirely" to the new requirement. Donna Cohen Ross, *New Medicaid Citizenship Documentation Requirement Is Taking a Toll*, Ctr. on Budget & Pol'y Priorities, at 3 (Mar. 13, 2007). The review also found that applicants were failing to enroll or renew "despite, from all appearances, being U.S. citizens." *Id.* The proof-of-

citizenship requirement's burdens were falling even on those the policy did not mean to exclude. *Id.*

A 2014 study of Medicaid enrollment among children in Oregon bore out those findings. *See* Brigit A. Hatch et al., *Citizenship Documentation Requirement for Medical Eligibility: Effects on Oregon Children*, 46 Family Med. 267 (2014).[6] The study found that many children rejected or excluded by the proof-of-citizenship requirement were U.S. citizens and would have been enrolled or renewed absent the requirement. *Id.* at 270.[7] Moreover, "socially and medically vulnerable" children were more likely to be rejected. *Id.* As a consequence, they skipped doctor's and dentist's visits and missed prescriptions, causing their health needs to go unmet. *Id.* at 272.

4. Evidence of administrative burdens' effect on enrollment comes also from CHIP. Like Medicaid, CHIP is a public health program funded and overseen by the federal government and administered by the States. Its state-by-state variation facilitates study of how administrative burdens affect enrollment and retention, and that research has yielded findings consistent with studies of Medicaid.

Congress enacted CHIP in 1997. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-70, codified as amended at 42 U.S.C.

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[6] This study was funded by the Agency for Healthcare Research and Quality ("AHRQ") within HHS. *See* Hatch, 46 Family Med. at 274.

[7] A 2016 study of enrollees in Georgia likewise found that the "vast majority" of those excluded by the proof-of-citizenship requirement were citizens. James Marton et al., *Enhanced Citizenship Verification and Children's Medicaid Coverage*, 54 Econ. Inquiry 1670, 1681 (July 2016).

§§ 1397aa-1397mm.[8] Within several years, it was evident that eligible children were losing coverage in large numbers. *See* Ian Hill & Amy Westpfahl Lutzky, *Is There a Hole in the Bucket? Understanding SCHIP Retention*, Urban Inst., Occasional Paper No. 67, at 8 (May 2003).[9] An early review found that from one-third to one-half of children were unable to renew their coverage. *Id.* at 12. The review attributed CHIP's poor retention in large part to the "hassle factor" of renewal. *Id.* at 8-9. Families struggled to understand the requirements for renewal and to gather the necessary documentation of income, residency, and other criteria. *Id.* at 8-10.

A 2005 study of CHIP's retention problems found that 28% of children on CHIP or Medicaid in a given year were not in the program a year later and, of those, 45% lost coverage despite remaining eligible and not gaining other insurance. *See* Benjamin D. Sommers, *From Medicaid to Uninsured: Drop-Out among Children in Public Insurance Programs*, 40 Health Servs. Res. 59, 66 (Feb. 2005). Here, too, "administrative hassle" was a principal cause. *Id.* at 63. The study found that onerous recertification procedures – requiring renewal more than once a year and requiring a face-to-face interview – were associated with higher rates of drop-out. *Id.* at 65-66, 69.

Similarly, a national evaluation of CHIP in 2007 reviewed nine studies covering 22 States and concluded that "simplified renewal procedures" increased retention. Margo Rosenbach et al., *National Evaluation*

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[8] The CHIP program was then known as SCHIP, the State Children's Health Insurance Program.

[9] This study was part of a research project on CHIP led by ASPE. *See* Hill & Lutzky, *Is There a Hole in the Bucket?* at vii.

of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access, Mathematica Pol'y Res., Final Report at 28 (Sept. 2007).[10] The evaluation looked in particular at simplifications to the renewal process that six States undertook from 1999 to 2001 once CHIP's poor retention had become evident. *Id.* at 31. Children who enrolled after the simplifications were more likely to remain enrolled. *Id.*

The history of CHIP in Florida furnishes a vivid illustration of the effect that administrative burdens have on enrollment and retention. A 2002 study compared Florida's retention rates with New York, Kansas, and Oregon. *See* Andrew W. Dick et al., *Consequences of States' Policies for SCHIP Disenrollment*, 23 Health Care Fin. Rev. 65 (Spring 2002).[11] Unlike the other States, Florida employed "passive re-enrollment." *Id.* at 69. Families were not obligated to resubmit documentation of their income. Instead, Florida checked family income with its own computer systems and presumed children remained eligible unless information showed the contrary. *Id.* In the three other States, approximately one-half of the children dropped out of the States' CHIP programs at every recertification. *Id.* at 82. In Florida, by contrast, the same "precipitous drop off in enrollment at the time of recertification" did not occur, thanks to passive re-enrollment. *Id.* at 83.[12]

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[10] This report was prepared under a contract with CMS. *See* Rosenbach, *National Evaluation of the State Children's Health Insurance Program* at ii-iii.

[11] This study was funded in part by AHRQ and included co-authors from the agency.

[12] This study also drew attention to the frequency of recertification. Oregon, Kansas, and New York suffered comparable

Florida provided further demonstration of administrative burdens' effect on enrollment when it replaced passive re-enrollment with "active redetermination" in 2004. *See* Jill Boylston Herndon et al., *The Effect of Renewal Policy Changes on SCHIP Disenrollment*, 43 Health Servs. Res. 2086, 2088 (Dec. 2008). Where Florida previously had checked eligibility itself, it now required families to complete an annual "Renewal Request Form" with proof of income and with information about the family's access to employer-sponsored coverage. *Id.* at 2088-89. This study gauged the effect of the policy change by measuring the monthly frequency of disenrollment. It found "almost a 10-fold increase in disenrollment in a renewal month after the policy change." *Id.* at 2099-100.

5. Congress's reforms to Medicaid and CHIP reflect the accumulated lessons of experience regarding the effects of administrative burdens. In 2009, Congress reauthorized CHIP and incorporated a provision encouraging States to simplify their enrollment and renewal processes. *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 104, 123 Stat. 8, 17-23, codified as amended at 42 U.S.C. § 1397ee(a)(3), (4). Congress provided an incentive payment to States that adopted at least five of eight enrollment and retention provisions: continuous eligibility; liberalizing asset tests by using state data or by eliminating them altogether; eliminating face-to-face interview requirements; using joint applications for Medicaid and CHIP; automatic

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coverage losses at recertification, but Oregon required it twice as often – every six months instead of every 12. Consequently, Oregon's coverage losses were compounded. *See* Dick, 23 Health Care Fin. Rev. at 74, 82.

renewal; presumptive eligibility; "express lane" enrollment based on eligibility for SNAP, Head Start, or other programs; and subsidies to assist with premium payments. 42 U.S.C. § 1397ee(a)(4)(A)-(H).

In 2010, Congress addressed the simplification of Medicaid enrollment and renewal procedures in the Affordable Care Act. *See* Pub. L. No. 111-148, § 2201, 124 Stat. 119, 289-91 (2010), codified at 42 U.S.C. § 1396w-3. Instead of providing an incentive payment as with CHIP, Congress required States to adopt simplification measures as a condition of continued participation in Medicaid. *See* 42 U.S.C. § 1396w-3(a). Under a final rule issued by CMS in 2012,[13] those simplification measures included a bar on requiring renewals more frequently than every 12 months. *See* 42 C.F.R. § 435.916(a)(1). Another measure required States to use their own administrative data to determine eligibility, where possible, instead of requiring individuals to submit documentation. *See id.* § 435.916(a)(2).

The ACA and subsequent CMS rule also incorporated the lessons of experience with the proof-of-citizenship requirement. The ACA directed the Secretary to create a "coordinated eligibility and enrollment system," 77 Fed. Reg. at 17,159, to handle applications for Medicaid, CHIP, and the new exchanges created by the ACA. *See* 42 U.S.C. § 18083. CMS's 2012 final rule permitted the burden of proving citizenship to be lifted off individuals and families. Instead, the Secretary set up an electronic service for States to verify citizenship, along with other information. *See* 42 C.F.R. § 435.949.

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[13] Final Rule, Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144 (Mar. 23, 2012).

In the CHIP and ACA provisions addressing enrollment simplification, Congress recognized that administrative burdens discourage enrollment and undermine retention. CMS did the same through its 2012 rule on Medicaid enrollment simplification. In each of these instances, the frequency and difficulty of renewing coverage were particular objects of attention. The record of legislative and regulatory action thereby indicates that the risk of coverage loss is an "important aspect," *Motor Vehicle Mfrs. Ass'n of United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), of Medicaid enrollment and renewal procedures.

B. Work Requirements Impose Severe Administrative Burdens On Enrollees, Leading To Coverage Loss

In comments and letters to the Secretary, *amici* argued that work requirements can cause coverage losses, resulting in adverse health consequences. For example, *amici* and other organizations wrote to the CMS Administrator in May 2018, voicing a concern that "work requirements will likely result in patients and consumers losing access to the care they need to manage their condition(s) or inappropriately forcing beneficiaries into work situations that may worsen their health in order to maintain coverage." CAN Letter at 3. Similarly, in an August 2018 letter to the Secretary concerning New Hampshire's application, *amici* and other organizations cited evidence from Washington and Arkansas showing that reporting requirements resulted in a decrease in health care coverage. *See* ACHA Letter at 2-3. There are at least three reasons why work requirements can result in a loss of Medicaid coverage.

1. Medicaid beneficiaries face substantial obstacles to compliance with program reporting requirements,

including language barriers, disabilities, mental illness, limited Internet access, and insecure housing. *See* CAN Letter at 4. These barriers can cause beneficiaries to fail to report the work they perform, resulting in a loss of coverage.

Take access to the Internet. Arkansas Works required beneficiaries aged 19 to 49 to report "at least 80 hours per month" of work or other qualifying activities to the State. *See* App. 3a. The State's Department of Human Services ("DHS") "set up an online portal as its primary mechanism for beneficiary reporting." Ian Hill & Emily Burroughs, *Lessons from Launching Medicaid Work Requirements in Arkansas*, Urban Inst., at 15 (Oct. 2019) ("Hill & Burroughs").

But Arkansas is "ranked last among US states in the share of residents with broadband internet," and "most people enrolled in Arkansas Works do not own their own computers." *Id*. Indeed, in 2018, 31% of Arkansans to whom the proposed work requirements would apply had no Internet access in their household. *See* Anuj Gangopadhyaya et al., *Medicaid Work Requirements in Arkansas*, Urban Inst., at 18 (May 2018) ("Gangopadhyaya"). Some enrollees described having "to travel to places like public libraries to find a computer," despite "lack[ing] reliable means of transportation." Hill & Burroughs at 15. Without reliable Internet access, it is difficult for enrollees to access DHS's online portal, making reporting work more burdensome.

2. It is often unclear to beneficiaries whether work requirements even apply to them. When Arkansas tried to contact beneficiaries about the new work requirements, for example, the State's DHS reported receiving "a very high volume of returned and undelivered mail," reflecting the fact that lower-

income populations often are "transient" and "highly mobile." Hill & Burroughs at 7. And, without regular access to the Internet or email, many beneficiaries were unable to access DHS's online information about the work requirements. *See id.* When Medicaid beneficiaries have received notice of work requirements, they have "universally raised concerns" that the requirements are described in terms that are "too dense and confusing." *Id.* at 8. One health care case manager described an Arkansas DHS notice letter as a "blanket of words" that was "very hard to understand." *Id.*

A survey conducted after Arkansas's work requirements had been in place for several months found that "44% of the target population was unsure whether the requirements applied to them." Benjamin D. Sommers et al., *Medicaid Work Requirements – Results from the First Year in Arkansas*, 381 New Eng. J. Med. 1073, 1080 (Sept. 2019). This lack of awareness "may explain why thousands of persons lost coverage even though more than 95% of the target population appeared to meet the requirements or qualify for an exemption." *Id.* at 1079.

3. Even if they are aware of the work requirements and reporting obligations, Medicaid enrollees often face a lack of consistently available work hours. *See* Gangopadhyaya at 22. This "may reflect high rates of turnover in low-wage jobs," a "high prevalence of seasonal work," or other significant barriers to long-term employment. *Id.* In addition, 78% of Arkansans to whom the proposed work requirements applied faced at least one substantial barrier to working (like a serious health limitation or no access to a car or to the Internet). *Id.* at 18. As a result, many enrollees "fall in and out of compliance" with work requirements, resulting in "interruptions in

Medicaid coverage and access to health care." *Id.* at 22.

4. As a result of these barriers, 18,164 Arkansans were disenrolled between June and December 2018 for not meeting the work requirements. *See* Hill & Burroughs at 18. According to the State's database, only about 2,000 of these beneficiaries who lost coverage found new work, and there is no evidence that they secured employer-sponsored health insurance coverage. *See id.* at 13-14; *see also* Sommers, 381 New Eng. J. Med. at 1079 (finding "a significant increase in the percentage of adults who were uninsured" after the imposition of work requirements in Arkansas, which suggests that "many persons who were removed from Medicaid did not obtain other coverage").

When the Secretary approved the waiver requests at issue here, he failed to address any of the evidence showing that work requirements can cause coverage losses. The Secretary's Arkansas approval letter acknowledged the "[m]any commenters" who "emphasized that the community engagement requirements would be burdensome for individuals and families or create barriers to coverage for non-exempt people who might have trouble accessing care." App. 138a. But the Secretary did not explain how onerous reporting requirements, program information that is hard to obtain, and substantial barriers to stable employment promote community engagement or help increase involvement in beneficiaries' personal health care. Merely acknowledging the commenters' concern is not enough: agency action is arbitrary and capricious where, as here, it entirely fails to address that important concern and the evidence supporting it. *See State Farm*, 463 U.S. at 43.

C. The Secretary Failed To Address Evidence That Coverage Losses Can Result In Disruptions Of Care And Adverse Health Outcomes Without Increasing Employment

The Secretary's Arkansas approval letter also stated that CMS "believe[s] that the community engagement requirements create appropriate incentives for beneficiaries to gain employment" and that "employment is positively correlated with health outcomes." App. 138a. But the Secretary cited no evidence in support of this belief and ignored the evidence, presented by *amici* and others, that work requirements do not lead to increased employment or improved health outcomes.

1. Work requirements do not increase employment in part because "[m]ost people on Medicaid who can work already do so." ACHA Letter at 3. For example, a study of Michigan Medicaid beneficiaries – included in *amici*'s comment on New Hampshire's waiver – found that approximately 28% of the State's enrollees were unemployed; two-thirds of this group reported having a chronic physical condition, while another quarter reported having "a mental or physical condition that interfered with their ability to work." *Id*. (citing Renuka Tipirneni et al., *Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan*, 178 JAMA Internal Med. 564 (Apr. 2018)). Nearly 49% were already employed, more than 11% were "unable to work," and the remainder were retired, students, or homemakers. Tipirneni, 178 JAMA Internal Med. at 566.

Evidence from Arkansas Works supports the conclusion that work requirements do not increase employment. Implementation of the requirements "was

associated with significant losses in health insurance coverage in the initial 6 months of the policy but no significant change in employment." Sommers, 381 New Eng. J. Med. at 1079. The requirements did not result in "any significant change" either in employment "or in the related secondary outcomes of hours worked or overall rates of community engagement activities." *Id*. at 1080.

Indeed, evidence indicates that the Secretary's view – that conditioning Medicaid enrollment on work will increase employment – has cause and effect backwards. *See* ACHA Letter at 3 (citing Ohio Dep't of Medicaid, *2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment* (Aug. 2018) ("*2018 Ohio Medicaid Group VII Assessment*")). In a study of Medicaid beneficiaries in Ohio, 84% of employed beneficiaries reported that Medicaid made it easier to work, and 60% of unemployed beneficiaries reported that Medicaid made it easier for them to look for work. *See 2018 Ohio Medicaid Group VII Assessment* at 4.

2. A beneficiary that is disenrolled from Medicaid is unlikely to gain other coverage. Given the low incomes of Medicaid beneficiaries, few are able to afford private insurance. *See, e.g.*, Jeff Levin-Scherz & Steve Nyce, *Making Health Care Affordable for Low-Wage Workers*, Harv. Bus. Rev. (May 23, 2019) (noting that low-wage workers often cannot afford an unexpected expense like the purchase of a new insurance product and that "41% of Americans would have to sell something to be able to afford an unexpected expense of over $400").

And it is well-established that low-wage employers seldom provide coverage. "Employees in low-wage

businesses have significantly worse access to employment-based insurance than other employees do." Stephen H. Long & M. Susan Marquis, *Low-Wage Workers and Health Insurance Coverage: Can Policymakers Target Them through Their Employers*, 38 Inquiry: J. Health Care Org., Provision, & Fin. 331, 331 (Fall 2001). In 2018, for example, just 24% of full-time workers below the poverty line were covered by an employer-sponsored plan. *See* Matthew Rae et al., *Long-Term Trends in Employer-Based Coverage*, Kaiser Family Found. (Apr. 3, 2020). Of workers earning between 100% and 250% of the poverty line, only 48% were covered by an employer-sponsored plan. *Id.* And the share of people with employer-based coverage fell from 1998 to 2018 for all income groups below 400% of the poverty line. *Id.*

3. Work requirements do not improve health outcomes because disenrollment from Medicaid and the subsequent failure to find replacement insurance often results in significant care disruptions. *Amici*'s letter opposing New Hampshire's waiver raised this concern, stressing that people with life-threatening diseases "rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions" and therefore "cannot afford a sudden gap in their care." ACHA Letter at 2.

For people with chronic conditions, including mental illness and substance-abuse disorders, "even the temporary loss of access to medications or other treatment could be harmful or sometimes catastrophic." Hannah Katch et al., *Taking Medicaid 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, at 4 (Aug. 13, 2018). Indeed, it is

"well documented that lack of coverage is associated with delays in seeking needed care, higher rates of chronic illness, and overall increased morbidity and mortality." Hill & Burroughs at 24.

One Arkansan with a chronic condition explained that, after he lost Medicaid coverage, he could not afford medications, which caused him to lose his job due to his deteriorating health. *See* Jennifer Wagner & Jessica Schubel, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements*, Ctr. on Budget & Pol'y Priorities, at 3 (Nov. 18, 2020). Others reported that losing Medicaid "affected their ability to obtain needed care, as well as their peace of mind, because they no longer knew how they would cope if they experienced a serious illness." Hill & Burroughs at 25.

Though *amici* warned the Secretary about the consequences of work requirements, the Secretary ignored the evidence and instead articulated an unfounded belief that work requirements could improve health outcomes.

D. The Secretary Ignored Accumulating Evidence That The Medicaid Work Requirements Cause Coverage Loss

As the Secretary continued to approve waiver applications, he refused to consider emerging evidence of the coverage losses caused by work requirements. Before the waivers requested by Arkansas and New Hampshire were approved, commenters had identified studies forecasting that the requirements would result in sharp declines in health care coverage. *See*, *e.g.*, Rachel Garfield et al., *Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses*, Kaiser Family Found., at 3-4 (June 2018) (estimating a 3-6% enrollment loss

among the total Medicaid population resulting from work requirements).

As discussed above, evidence from Arkansas showed that these forecasts were too conservative. Before the work requirements were suspended by the district court, roughly 25% of non-exempt Medicaid beneficiaries in the State were disenrolled from Medicaid. *See* Hill & Burroughs at 18. Data suggest that the primary cause of this disenrollment was a failure to comply with reporting requirements. In every month the work requirements applied, "more than 98 percent of beneficiaries subject to [them] reported no activity." *Id.*

Before New Hampshire's waiver was approved, patient groups including *amici* presented preliminary data from Arkansas to the Secretary. *Amici*'s August 2018 letter reported that, according to Arkansas's own records, nearly 12,000 enrollees failed to meet the reporting requirements for at least one month and therefore were at risk of losing coverage. ACHA Letter at 2. But the Secretary declined to address this evidence.

It is true that federal agencies enjoy considerable discretion and that the scope of judicial review under the "arbitrary and capricious" standard is "narrow." *State Farm*, 463 U.S. at 43. But the agency must nonetheless "examine the relevant data" and present a rational explanation for its decision. *Id.* In this case, the Secretary utterly failed to address the relevant evidence showing the harmful consequences of imposing work requirements on Medicaid enrollees. Vacatur of the decisions approving these requirements was therefore appropriate.

II. THE SECRETARY'S EVIDENCE DID NOT SUPPORT HIS DECISIONS

In the Secretary's Arkansas approval letter, he wrote that Arkansas Works was "designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that *research has shown to be correlated with improved health and wellness*." App. 133a-134a (emphasis added). The Secretary cited two sources for this proposition: Gordon Waddell & A. Kim Burton, *Is Work Good for Your Health and Well-Being?* (2006) ("Waddell & Burton, *Is Work Good*"); and Maaike van der Noordt et al., *Health effects of employment: a systematic review of prospective studies*, 71 Occup. & Envtl. Med. 730 (2014). Arkansas now contends that the Secretary made a reasonable prediction that Arkansas's waiver "would likely promote beneficiary health and independence." Ark. Br. 48. But neither source supports the Secretary's decisions.

1. To start, neither review was focused on the United States. Waddell and Burton, both based in the United Kingdom, were commissioned by the British government and relied mostly on studies conducted in the U.K. Van der Noordt and her co-authors are based in the Netherlands and relied mostly on studies conducted in continental Europe. The U.K. and other European countries have universal health care systems that, through various policy designs, cover the entire population. *See* Ministry of Health, Gov't of Spain, *Health care systems in the European countries: Health characteristics and indicators 2019*, https://www.mscbs.gob.es/estadEstudios/estadisticas/docs/presentacion_en.pdf. That limits the studies' relevance for work requirements that can result in a loss of health insurance.

Because, as discussed above, being uninsured is the likely consequence of the work requirements for many people, a study of the health benefits of employment offers little insight if it is conducted in a country with universal health care. The universality of coverage means that the main threat to enrollees' health resulting from the work requirements at issue here – the loss of coverage – cannot happen in the countries studied. For that reason, the Waddell & Burton and van der Noordt research has little to say about the health benefits of work requirements imposed in the United States.

2. In fact, to the extent the two reviews have germane insights, they are contrary to the Secretary's decision. The Waddell & Burton review addressed, among other topics, a set of "social security studies," in which recipients of cash benefits stopped receiving them and moved into the workforce. Waddell & Burton, *Is Work Good* at 29. These studies considered a proposition similar to that advanced by the Secretary: that moving off benefits and into work is likely to increase income, human or social capital, and social status, thereby improving individuals' health, quality of life, and well-being. *Id.* Based on those studies, Waddell and Burton drew a critical distinction between those who left benefit programs voluntarily and those who were forced off: "interventions which encourage and support claimants to come off benefits and successfully get them (back) into work are likely to improve their health and well-being; *interventions which simply force claimants off benefits are more likely to harm their health and well-being*." *Id.* at 30 (emphasis added).

The Arkansas and New Hampshire waivers work in a coercive manner: failure to complete and report the requisite hours of work results in disenrollment.

They operate only as sticks, not carrots. Consequently, the Waddell & Burton review suggests that the Arkansas and New Hampshire waivers are likely to harm health and well-being, the opposite of the point for which the Secretary cited it.

The two reviews also offered a warning about the types of jobs that the Arkansas and New Hampshire work requirements would likely push Medicaid enrollees to take. Waddell and Burton noted that many claimants go into "poorly paid or low quality jobs, and insecure, unstable or unsustained employment" after leaving benefits programs. *Id.* at 29. These cases led to "further periods of unemployment or sickness." *Id.* The van der Noordt review added that "[l]ow-quality jobs can lead to reduced health." van der Noordt, 71 Occup. & Envtl. Med. at 735.

As noted above, for unemployed people on Medicaid, good job opportunities can be hard to find. If they can obtain work, it is likely to be low-paying and insecure. In that event, the two reviews cited by the Secretary indicate that worsened health is the probable result.

3. Because the Secretary's cited authorities do not support his decision, it may be tempting to rationalize the demonstration projects as an effort to fill a gap in the social-science literature. This is impermissible as a legal matter. *See State Farm*, 463 U.S. at 43 ("We may not supply a reasoned basis for the agency's action that the agency itself has not given.") (citing *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)). It is also contrary to the record as a factual matter.

In the Secretary's New Hampshire approval, he retreated from the assertion that scholarly research predicts health benefits will result from tying Medi-

caid enrollment to compliance with work requirements. The Secretary no longer cited the Waddell & Burton review, the van der Noordt review, or any such work.

The Arkansas approval also cannot be rationalized as an effort to fill a gap in the literature, because Arkansas did not propose a meaningful evaluation plan in its application and implemented the work requirements without timely finalizing an evaluation design.

CMS regulations provide that an application for a Section 1115 waiver is not complete without an evaluation design identifying the "research hypotheses" the project is meant to test, a plan for testing them, and "appropriate evaluation indicators." 42 C.F.R. § 431.412(a)(1)(vii).[14] Arkansas presented its proposed work requirements to CMS as a redline amendment to its existing Arkansas Works waiver. *See* Letter from Asa Hutchinson, Governor, State of Arkansas, to Thomas E. Price, Secretary, U.S. Dep't of Health & Human Servs. (June 30, 2017).[15] The amendment left the existing section on evaluation design nearly unchanged, identifying only one new research hypothesis related to work requirements: that "[w]ork requirements will increase the number of Arkansas Works beneficiaries who are employed." *Id.* at pdf p. 36. The amendment did not identify any research hypotheses related to improved health along the lines that Arkansas now urges.

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[14] This evaluation design is not to be confused with the simple tracking of enrollment numbers, which Arkansas carried out.

[15] Documents relating to CMS's approval of the Arkansas waiver are available here: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81021.

Moreover, Arkansas implemented the work requirements without establishing an evaluation design. The Secretary approved the Arkansas waiver on March 5, 2018. *See* App. 129a-143a. The approval's terms and conditions gave Arkansas 120 days to submit an evaluation design, later than the June 1 onset of the work requirements. *See* App. 142a, No. 20-38. Arkansas submitted its evaluation plan in August 2018, and CMS gave initial feedback in November 2018. *See* Letter from Andrea J. Casart, Dir., Div. of Medicaid Expansion Demonstrations, to Dawn Stehle, Medicaid Dir., Arkansas Dep't of Human Servs. (Nov. 1, 2018). As of March 2019, when the district court vacated the Secretary's approval, Arkansas still had not secured a vendor to carry out the evaluation. *See* Arkansas Dep't of Human Servs., Arkansas Works Section 1115 Demonstration Waiver at 9 (Mar. 1, 2019). By then, the work requirements had been in effect for nine months.

Arkansas's approach to evaluation does not evince a genuine interest in generating legitimate findings on the health effects of work requirements. Instead, it is yet more indication that the Secretary's decisions were arbitrary and capricious.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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