Nos. 20-37, 20-38

IN THE
Supreme Court of the United States

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

STATE OF ARKANSAS,
Petitioner,
v.
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On Writs of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF OF HEALTH CARE PROVIDER ORGANIZATIONS AND PATIENT GROUPS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS GRESHAM ET AL.

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STATEMENT OF INTEREST[1]

American Cancer Society Cancer Action Network, American College of Obstetricians and Gynecologists,

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amici curiae*, their members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

American College of Physicians, Cancer Support Community, Catholic Health Association of the United States, Cystic Fibrosis Foundation, Epilepsy Foundation, Hemophilia Federation of America, Judge David L. Bazelon Center for Mental Health Law, March of Dimes, Mental Health America, National Coalition for Cancer Survivorship, National Multiple Sclerosis Society, National Patient Advocate Foundation, and The AIDS Institute respectfully submit this brief as *amici curiae* in support of Respondents Gresham et al.

American Cancer Society Cancer Action Network empowers advocates to make cancer a top priority for government officials. Medicaid plays a vital role in providing affordable healthcare coverage to lower income cancer patients and survivors, ensuring they have access to critical treatment and survivorship care. More than two million Americans with a history of cancer rely on Medicaid.

American College of Obstetricians and Gynecologists (ACOG) is the specialty's premier professional membership organization dedicated to the improvement of women's health. With more than 60,000 members representing more than 90 percent of board-certified ob-gyns in the United States, ACOG is dedicated to the advancement of women's healthcare, including advancing the core value of access for all women to high quality safe healthcare.

American College of Physicians (ACP) is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. ACP membership includes 163,000 internal medicine physicians (internists), related subspecialists, and medical students.

Cancer Support Community (CSC) is the largest non-profit provider of social and emotional support services for people affected by cancer. CSC believes that all patients should have access to comprehensive, high-quality, timely, and affordable medical and psychosocial care, including those who rely on Medicaid for their healthcare coverage.

Catholic Health Association of the United States is the national leadership organization of the Catholic health ministry. Comprised of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation.

Cystic Fibrosis Foundation's (CFF's) mission is to cure cystic fibrosis (CF) and to provide all people with CF the opportunity to lead long, fulfilling lives by funding research and drug development, partnering with the CF community, and advancing high-quality, specialized care. CFF advocates for policies that promote affordable, adequate, and available healthcare coverage for all people with CF, including the 50 percent of children and one third of adults with CF who rely on Medicaid.

Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of more than 3.4 million Americans with epilepsy and seizures. Timely access to quality, affordable, physician-directed, and person-centered care and effective coverage for epilepsy medications is vital for all people living with epilepsies.

Hemophilia Federation of America is a community-based, grassroots advocacy organization that educates on behalf of and advocates for people with hemophilia,

von Willebrand disease, and other rare bleeding disorders.

Founded in 1972 as the Mental Health Law Project, the Judge David L. Bazelon Center for Mental Health Law is a national non-profit advocacy organization that provides legal assistance to individuals with mental disabilities. The Center works to advance the rights and dignity of individuals with mental disabilities in all aspects of life. Ensuring access to Medicaid-funded services that enable people to live, work, and thrive in their own homes and communities has been central to the Center's mission and focus.

March of Dimes is the leading non-profit organization fighting for the health of all moms and babies. It promotes the health of women, children, and families, across the life course, from birth through adolescence and the childbearing years, with an emphasis on preconception, prenatal, interconception, and infant health. Medicaid provides comprehensive prenatal care to millions of pregnant women.

Mental Health America—founded in 1909—is the nation's leading community-based non-profit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all Americans. Its work is driven by its commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, and integrated care, services, and support for those who need it, with recovery as the goal.

National Coalition for Cancer Survivorship advocates for quality cancer care for all people touched by cancer. It represents millions of Americans who share a common experience—the survivorship experience—living with, through, and beyond a cancer diagnosis.

National Multiple Sclerosis Society is devoted to ensuring people affected with MS can live their best lives and to ending MS forever. MS is an unpredictable, often disabling disease with no known cause or cure, and highly variable in its impact on the nearly one million people in the United States currently living with MS. Access to comprehensive healthcare and coverage, including Medicaid, is essential for individuals and families touched by MS.

National Patient Advocate Foundation (NPAF) is dedicated to elevating patient and caregiver voices as part of improving equitable access to affordable quality care, particularly for the most underserved populations. NPAF is the advocacy affiliate of Patient Advocate Foundation (PAF), a national organization that provides direct assistance to families coping with complex and chronic health conditions to help meet their most pressing needs for financial and social services advocacy and support.

The AIDS Institute is a national leader dedicated to supporting and protecting healthcare access for people living with HIV/AIDS, Hepatitis, and patients living with chronic diseases.

INTRODUCTION AND SUMMARY OF ARGUMENT

Arkansas's first-in-the-nation Medicaid work requirements disenrolled over 18,000 beneficiaries in its first six months—essentially all were left without coverage. New Hampshire's Medicaid work requirements were likewise scheduled to disenroll 17,000 Medicaid enrollees—roughly 40 percent of beneficiaries subject to the new work requirements. Those beneficiaries would have lost coverage had the State not intervened to suspend the program a month after its launch.

These losses in coverage were predictable. If a State takes Medicaid coverage away from beneficiaries who do not satisfy work or reporting requirements, fewer people in that State will have healthcare coverage. The U.S. Department of Health and Human Services (HHS), however, resists this obvious conclusion. HHS Br. 30-34. It asserts that kicking beneficiaries off Medicaid for a failure to meet work or reporting requirements could ultimately allow a State to "preserve or extend" healthcare coverage by stretching its limited resources further. *Id.* at 32, 35.

The agency proposes two ways work requirements will "enable States to stretch limited Medicaid resources" further by conserving Medicaid dollars while maintaining the same number of individuals with some form of healthcare coverage. *Id.* at 31. For one, work requirements purportedly will enhance private coverage by "incentiv[izing]" non-working beneficiaries to find a job. *Id.* at 31-32. That, in turn, purportedly will facilitate employer-sponsored insurance (ESI) or individual market health insurance coverage. *Id.* at 32. Alternatively, HHS asserts that work

requirements will make the beneficiary population healthier and thus less expensive to treat. *Id.* at 33.

HHS goes so far as to assert that work requirements may even expand or enhance coverage by "freeing up the funds" a State could then spend "providing coverage for additional individuals or providing additional benefits." *Id.* at 30.

HHS is wrong. Medicaid work requirements will not facilitate private coverage. Most beneficiaries work. And those who do not face enormous barriers to securing reliable employment. Moreover, non-working beneficiaries who eventually find a job will disproportionately obtain employment that does not offer ESI or pay enough to afford individual market health insurance coverage. On top of that, thousands of *working* beneficiaries will lose coverage because they do not comply with a State's separate reporting requirements. Work and reporting requirements will reduce —not preserve—healthcare coverage.

Nor will tying Medicaid to work make beneficiaries "healthier." *Id.* at 33. HHS believes work requirements will lead to greater employment, which will make beneficiaries healthier and thereby "reduce[] the cost of providing them health-care coverage." *Id.* But, again, nearly all beneficiaries who can work do. Rather than encouraging healthy behavior, work requirements will simply strip beneficiaries of coverage. And losing coverage, even for a short period of time, will make beneficiaries sicker and ultimately *less* employable.

Finally, work requirements will not lead to savings that allow States to "extend" coverage. *Id.* at 35; *see also id.* at 29, 35 (asserting work requirements "conserve" resources). To the contrary, Medicaid work

requirements *waste* State resources. Simply setting up and administering a work and reporting requirements program costs tens of millions of dollars. Moreover, States will face significant additional costs as beneficiaries who satisfy the work and reporting requirements for some periods but not others churn in and out of the Medicaid program.

In short, HHS's conjecture that Medicaid requirements will preserve or extend healthcare coverage by spreading State resources further is not grounded in reality. The court of appeals' decision should be affirmed.

ARGUMENT

I. REQUIRING MEDICAID BENEFICIARIES TO WORK WILL NOT FACILITATE PRIVATE COVERAGE.

Because work requirements do not increase employment, they do not facilitate private coverage. HHS speculates that work requirements will prompt non-working beneficiaries to find a job, which will get more beneficiaries insured through ESI or individual market health insurance coverage. *Id.* at 31-32. But most non-working beneficiaries are unemployed because they face insurmountable obstacles to securing a steady job. And the large majority of non-working beneficiaries who eventually find employment will *still* be unable to obtain private coverage. Moreover, thousands of *working* beneficiaries will lose coverage for failing to comply with a State's complicated reporting requirements.

A. Medicaid Work Requirements Do Not Increase Employment Because Non-Working Beneficiaries Face Exceedingly High Structural Barriers To Securing A Steady Job.

Medicaid work requirements do not increase employment, as the Arkansas experience confirms. Arkansas is the only State to actually disenroll beneficiaries under a work requirements program. And, there, the program "was associated with significant losses in health insurance coverage * * * but no significant change in employment." Benjamin D. Sommers et al., *Medicaid Work Requirements — Results from the First Year in Arkansas*, 381 New England J. Med. 1073, 1079 (Sept. 12, 2019) (*Results from the First Year*).[2]

By April 2019, 18,164 Arkansas beneficiaries were stripped of coverage. Ian Hill & Emily Burroughs, Urb. Inst., *Lessons from Launching Medicaid Work Requirements in Arkansas* 1-2, 13-14 (Oct. 2019) (*Lessons from Arkansas*).[3] Over the next two months, less than 2,000 of them went from unemployed to employed. *Id.* And that smaller-than-2,000 jobs gain was expected *regardless of* the work requirements because "low-income people move in and out of jobs frequently under any circumstances." Jennifer Wagner & Jessica Schubel, Ctr. on Budget & Pol'y Priorities, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements* 8 (updated Nov. 18, 2020) (*States' Experiences*).[4] Ultimately, there is "no evidence that the policy succeeded in its stated goal of

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[2] https://bit.ly/37H4pSl.

[3] https://urbn.is/2Nm1Kqf.

[4] https://bit.ly/3bu56PU.

promoting work." Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 Health Affs. 1522, 1529 (Sept. 2020) (*Two-Year Impacts*).[5]

There is a simple explanation: Virtually all beneficiaries who can work do work. One study found that *95 percent* of Arkansas beneficiaries worked enough to meet work requirements or qualified for an exemption. *Results from the First Year*, *supra*, at 1079; *Two-Year Impacts*, *supra*, at 1529; *see also* Ian Hill et al., Urb. Inst., *New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results* 7 (Feb. 10, 2020) (*New Hampshire's Experience*) (explaining that "the vast majority of Medicaid beneficiaries who could work were working").[6] The remaining sliver of non-working beneficiaries cannot find jobs because massive structural barriers stand in their way—not because they lack the right "incentive[s]." HHS Br. 32. Because work requirements do nothing to address those structural barriers, they fail to increase employment.

First, many non-working beneficiaries subject to work requirements have a physical or mental condition that makes it difficult to find and keep a job. Thirty-four percent of non-working Medicaid beneficiaries who do not qualify as disabled for Social Security purposes nevertheless "live with multiple chronic medical conditions such as hypertension, high cholesterol, arthritis, or heart disease." Rachel Garfield et

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[5] https://bit.ly/3su7pcJ.

[6] https://urbn.is/2NoFk7M.

al., Henry J. Kaiser Fam. Found., *Understanding the Intersection of Medicaid and Work: What Does the Data Say?* 8 (Aug. 2019) (*Understanding the Intersection*).[7] And 51 percent have a functional limitation: Eighteen percent report difficulty walking 100 yards, while 23 percent report difficulty walking up or down a flight of stairs. *Id.* That is a particular challenge for Medicaid beneficiaries, who generally are most qualified for "physically demanding" jobs. *Id.* at 6. Indeed, the two industries that employ the most beneficiaries are, by far, restaurants and food service and construction. *Id.*; *see also* Aviva Aron-Dine et al., Ctr. on Budget & Pol'y Priorities, *Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements* 6 (Apr. 11, 2018) (*Many Working People*).[8]

Non-working beneficiaries also disproportionately experience mental illness, and the stigma that it carries. More than a third of non-working Medicaid adults report depression. *Understanding the Intersection*, *supra*, at 8. Thousands more have mental-health conditions that make it difficult for them to "concentrat[e], remember[], or mak[e] decisions." Anuj Gangopadhyaya et al., Urb. Inst., *Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know About Them?* 17 (May 2018) (*Arkansas, Who's Affected?*).[9] Especially without accommodations or supported employment services, these mental-health challenges can cause "unpredictable breaks

[7] https://bit.ly/3aH4gA8.

[8] https://bit.ly/3qKcugr.

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

in availability of work," raising the barriers to securing steady employment even higher. Lynne M. Harris et al., *Perspectives on Barriers to Employment for Job Seekers with Mental Illness and Additional Substance-Use Problems* 22 Health & Soc. Care in the Cmty. 67, 70 (2013).[10]

Second, non-working Medicaid beneficiaries are disproportionately clustered in high-unemployment areas. Medicaid beneficiaries are "more than twice as likely as privately insured adults to live in census tracts with unemployment that is over twice the national average." Michael Karpman, Urb. Inst., *Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment* 6 (May 30, 2019) (*Barriers*).[11] As a result, the jobs that HHS wants to "incentiv[ize]" beneficiaries to pursue simply do not exist where beneficiaries actually live. HHS Br. 32.

Take New Hampshire. As of June 2018, the same county (Coos County) had both the highest unemployment rate in the State and the highest percentage of the State's population enrolled under the new Medicaid eligibility expansion—the only beneficiaries subject to New Hampshire's new work requirements. Inst. for Health Pol'y & Prac., Univ. of N.H., *Covering the Care: Medicaid, Work, and Community Engagement* 4 (June 2018).[12] These regional disadvantages are compounded because, especially in rural areas, many unemployed Medicaid enrollees lack a reliable source of transportation to and from a potential job. *Arkansas, Who's Affected?*, *supra*, at 14; *see also*

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[10] https://bit.ly/3btGSVU.

[11] https://urbn.is/3btThJr.

[12] https://bit.ly/3dBkbSr.

Barriers, *supra*, at 5 (finding that, nationally, 14.6% of Medicaid recipients who would be subject to work requirements have limited access to transportation).

Third, 21.6% of non-exempt Medicaid beneficiaries did not complete high school. *Barriers*, *supra*, at 5; *see also Arkansas, Who's Affected?*, *supra*, at 13. Because "a high percentage of [available jobs] require higher education or specialized training," less-educated workers face greater hurdles in finding work. Bd. of Governors of Fed. Rsrv. Sys., *A Perspective from Main Street: Long-Term Unemployment and Workforce Development* 5, 30, 42 (Dec. 2012).[13] Using New Hampshire as an example again: In early 2019, "13,380 people with less education than a college degree were seeking jobs" in that State, but "there were just 6,132 job openings for people with that education level." *New Hampshire's Experience*, *supra*, at 8.

Employment barriers for workers with little education have only grown during the current health and economic crises. In August 2019, unemployment for workers without a high school diploma was 5.4%. Michael T. Nietzel, *Unemployment Rates During the Pandemic Are Much Lower for Adults with a College Degree*, Forbes (Sept. 8, 2020).[14] In April 2020, it shot up to a whopping 21.2%, and has since settled at around 12.6%. *Id.* Workers with a bachelor's or more advanced degree, by contrast, had a 2.1% unemployment rate in August 2019, which rose to only 8.4% in April 2020 and, as of August 2020, dropped to 5.3%. *Id.* Now, just like before the pandemic, millions of workers without a high school degree are unable to

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

[14] https://bit.ly/3slHWSG.

find jobs despite their best efforts. Kicking them off Medicaid will not change that.

Fourth, non-working beneficiaries of all education levels struggle to find work after they have been unemployed for a long time. As of December 2020, more than 37 percent of those unemployed had been out of a job for more than six months. *See* Bureau of Lab. Stats., U.S. Dep't of Lab., *Table A-12. Unemployed Persons by Duration of Unemployment* (last modified Feb. 5, 2021).[15] And that statistic includes only those who had "actively looked for work in the prior 4 weeks." *See* Bureau of Lab. Stats., U.S. Dep't of Lab., *Labor Force Statistics from the Current Population Survey* (last modified Jan. 22, 2021).[16] From February to December 2020, an additional *3.7 million* individuals gave up on searching for employment and left the labor market altogether. Gwynn Guilford & Sarah Chaney Cambon, *Covid Shrinks the Labor Market, Pushing Out Women and Baby Boomers*, Wall. St. J. (Dec. 3, 2020).[17] These millions of workers will see their "skills atrophy, networks erode, and personal barriers to re-employment" increase. Rockefeller Found., *Long-Term Unemployment* 13 (May 2013).[18] Stigmatization of the long-term unemployed makes finding a job even more difficult. Unemployment status has become a "sorting criterion" for employers. Annie Lowrey, *Caught in a Revolving Door of Unemployment*, N.Y. Times (Nov. 16, 2013).[19] For "low- or

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[15] https://bit.ly/2P5aAcj.

[16] https://bit.ly/3dEhyPQ.

[17] https://on.wsj.com/3qKeDJ9.

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

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

medium-skilled jobs," it is significantly more difficult for those out of work for nine months or more to obtain even an interview. *Id.*

These obstacles are not hypothetical. In Arkansas, for example, 78 percent of non-working, non-exempt beneficiaries had less than a high school education, a serious health limitation, a household member with a serious health limitation, no access to a vehicle, or no Internet access. *Lessons from Arkansas*, *supra*, at 6. Given those barriers, it is unsurprising that Arkansas's Medicaid work requirements did not increase employment. *Results from the First Year*, *supra*, at 1079-81. If the program were replicated in other States, the same result would surely follow.

B. Non-Working Beneficiaries Who Do Find Employment Will Still Mostly Be Unable To Obtain Private Coverage.

There is another problem with HHS's logic: Even if a non-working beneficiary were to find a job, that job would be unlikely to yield private coverage. *See Lessons from Arkansas*, *supra*, at 7. Beneficiaries able to find work are mostly eligible only for part-time or seasonal jobs—employment that rarely offers ESI or increases the beneficiary's income to a level that allows for individual market health insurance coverage. *Contra* HHS Br. 32. By some estimates, 61.6% of non-exempt Medicaid beneficiaries[20] worked in 2019, but

[20] According to this study, "60 percent of nondisabled [adult, non-elderly] Medicaid enrollees in the sample would likely be exempt because they were pregnant in the past year, full-time students in the past year, or reported being primary caregivers of a dependent child or an adult family member." *Barriers*, *supra*, at 3. Even more would qualify under other exemptions, such as disability or medical frailty. *Id.*

only 14.9% worked at least 20 hours per week for all or nearly all weeks. *Barriers*, *supra*, at 7; *see also Many Working People*, *supra*, at 5 (reporting similar results from June 2012 to May 2013). That means even *working beneficiaries* are at risk of losing coverage under new work requirements. *Barriers*, *supra*, at 7; *Many Working People*, *supra*, at 1-2. Non-working beneficiaries who overcome the obstacles to finding a job would likely end up in the same position.

If beneficiaries find work, it is usually part-time or seasonal. *See Barriers*, *supra*, at 7-8; *Many Working People*, *supra*, at 6-7. Such jobs overwhelmingly do not provide ESI. In 2019, for example, ESI was offered to only 19 percent of Medicaid-eligible workers with part-time jobs. *Understanding the Intersection*, *supra*, at 11. Increasingly, ESI is becoming a privilege for highly educated and highly compensated workers. As of March 2020, 94 percent of workers in the highest 10 percent income bracket were offered ESI, while only 27 percent of workers in the lowest 10 percent were given the option. Bureau of Lab. Stats., U.S. Dep't of Lab., *Employee Benefits in the United States – March 2020* 3 (Sept. 24, 2020).[21]

Nor do part-time or seasonal jobs ordinarily provide wages sufficient to allow for individual market health insurance coverage. *Contra* HHS Br. 32. In States that have expanded Medicaid eligibility under the ACA, like Arkansas and New Hampshire, subsidized individual market health insurance coverage through an Exchange is available only to individuals with a household income above 138 percent of the federal

[21] https://bit.ly/37BPb0A.

poverty limit. *See* Healthcare.gov, U.S. Ctrs. for Medicare & Medicaid Servs., *Medicaid Expansion and What It Means for You* (last visited Feb. 24, 2021).[22] And the part-time work for which beneficiaries are mostly qualified "dominate[s]" "certain lower-paying sectors or job[s]." Lonnie Golden, Econ. Pol'y Inst., *Part-Time Workers Pay a Big-Time Penalty: Hourly Wages-and-Benefits Penalties for Part-Time Work Are Largest for Those Seeking Full-Time Jobs and for Men, but Affect More Women* 1 (Feb. 27, 2020).[23] A minimum wage job, even if it offers 35 hours of weekly work, will still leave the worker below the federal poverty line—and far below the 138 percent Medicaid threshold. *Understanding the Intersection*, *supra*, at 5.

By and large, part-time workers would like to work more but do not have the option. Employers have an "incentive" to "keep a high number of workers on payroll (but with fewer hours available to each employee)," so that they can call in workers on short notice if demand picks up, or send them home if demand is slower than expected. Michael Karpman et al., Urb. Inst., *Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements* 3 (June 2019) (*Precarious Work Schedules*);[24] *see also* Lonnie Golden, Econ. Pol'y Inst., *Still Falling Short on Hours and Pay: Part-Time Work Becoming New Normal* 1 (Dec. 5, 2016) ("Retail and leisure and hospitality are among the key industries

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

[23] https://bit.ly/3uqugaT.

[24] https://urbn.is/2Nmvwev.

driving the structural shift toward involuntary part-time work").[25] As a consequence, there were 6 million "involuntary" part-time workers in January 2021, meaning that they would work full-time if their employer offered them more hours. Bureau of Lab. Stats., U.S. Dep't of Lab., *Commissioner's Statement on the Employment Situation* (Feb. 5, 2021).[26] There were 4.4 million involuntary part-time workers in February 2020. *Id.*

With these dynamics, over 80 percent of 2019 safety-net participants reported "some fluctuation in their weekly hours at their main job during the past month." *Precarious Work Schedules*, *supra*, at 8. Over half "have little to no input on when their workdays begin and end." *Id.* at 13. The "assumption that people who want to work can find steady employment at regular hours" is "out of step with the realities of the low-wage labor market." *Many Working People*, *supra*, at 6.

Accordingly, work requirements place 46 percent of *working* beneficiaries "at risk of losing coverage for one or more months." *Id.* at 1, 5. Of those who work at least 1,000 hours a year, 25 percent would be at risk of losing coverage for a period of time "because they would not meet the 80-hour requirement in *every* month." *Id.* at 2, 5. Most non-working beneficiaries who later find a job would suffer the same fate.

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[25] https://bit.ly/3keGw9N.

[26] https://bit.ly/2Nw6J7F.

C. Administrative, Technical, And Communication Barriers Will Deny Coverage Even To Beneficiaries Who Satisfy Work Requirements Or Are Exempt.

Work requirements will reduce—not preserve—coverage for still another reason. Complex *reporting* requirements will disenroll beneficiaries regardless of how many hours they work or if they qualify for an exemption. Arkansas and New Hampshire tell the same story—one that is bound to repeat every time a new State implements a Medicaid work requirements program.

In 2018, 18,164 Arkansans lost Medicaid coverage after the State implemented its work requirements. *Lessons from Arkansas*, *supra*, at 18. But most of those disenrolled beneficiaries either satisfied the work requirements or were exempt. *Results from the First Year*, *supra*, at 1081; *Two-Year Impacts*, *supra*, at 1529. Instead, the "coverage loss[]" was primarily due to the "bureaucratic" requirement that beneficiaries regularly *report* their hours worked or affirmatively claim an exemption. *Results from the First Year*, *supra*, at 1081.

The first problem was outreach. Arkansas attempted a "robust" campaign to inform beneficiaries of the new requirement to report their hours. *Lessons from Arkansas*, *supra*, at 8. The State sent 807,452 letters to beneficiaries' homes and 435,841 e-mails to beneficiaries' inboxes; made more than 300,000 calls; spent $959,399 to set up a call center, which ultimately received 31,000 calls; made 1,252 social media posts; participated in several radio and television interviews; made presentations at libraries, churches, colleges, and technical schools; and invited healthcare

plans and providers to implement their own outreach campaigns. *Id.* at 8-9.

But that was not enough. *Id.* at 10 (noting these efforts were "ultimately insufficient"); *see also States' Experiences*, *supra*, at 5 (describing how Arkansas's outreach "efforts failed to reach many enrollees"); MaryBeth Musumeci et al., Henry J. Kaiser Fam. Found., *An Early Look at Implementation of Medicaid Work Requirements in Arkansas* 4 (Oct. 2018) (*Early Look*) ("Despite a robust outreach campaign * * * many enrollees have not been successfully contacted").[27] Despite Arkansas's efforts, "[n]early half the target population was unsure whether the [work] requirements applied to them." *Results from the First Year*, *supra*, at 1077.

These outreach failures were particularly harmful because over half of nonelderly Medicaid adults in Arkansas report a disability but do not receive Supplemental Security Income from Social Security. MaryBeth Musumeci, Henry J. Kaiser Fam. Found., *Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018* 10 (June 2019).[28] Thousands of these enrollees lost coverage even though they qualified as "medically frail" and were "therefore exempt" from Arkansas's work requirements. *Id.*

The second problem was that Arkansas funneled its reporting system through an online portal. In fact, Arkansas began by "rel[ying] solely" on online reporting. *Early Look*, *supra*, at 14; *States' Experience*, *supra*, at 5. But more than half of Arkansans who

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

[28] https://bit.ly/3ulAsAZ.

needed to report their work hours had no broadband access, and one-quarter had no Internet access at all. *Arkansas, Who's Affected?*, *supra*, at 14. Eventually, the State offered "call center staff" to report hours, but that was still insufficient. *Lessons from Arkansas*, *supra*, at 17. In the end, failing to properly report work hours caused "more disenrollment" in Arkansas than actually failing to work. *Early Look*, *supra*, at 14; *see also Two-Year Impacts*, *supra*, at 1529 ("[B]arriers to reporting data to [Arkansas], rather than not meeting the requirements themselves, were the main cause for coverage losses").

New Hampshire resolved not to repeat those failures. State officials said that "[w]e are not Arkansas, we can do better," and expressed confidence that New Hampshire would not unintentionally disenroll working beneficiaries for failure to properly report their hours. *New Hampshire's Experience*, *supra*, at v. Instead of online-only submissions, New Hampshire designed a "no-wrong-door approach," where enrollees could "report their hours online, by mail, over the phone, or in person." *Id.* at 17-18. Moreover, the State "developed an outreach and education strategy they believed would be more robust and successful than Arkansas's." *Id.* at 10.

New Hampshire, however, did even worse than Arkansas. In June 2019, the first month the reporting requirements were in place, only 663 beneficiaries—out of 24,766 subject to the requirement—"actually reported their hours." *Id.* at 20. If the legislature had not intervened to suspend the program, mass disenrollment would have followed. *Id.* at 34.

In the New Hampshire Department of Health and Human Services Commissioner's own words: "[T]he

department ha[d] undertaken multiple efforts to explain the [work requirements] program, including 11 public information sessions, sustained advertisements on radio and social media, over 50,000 telephone calls, counseling sessions in each of the department's 11 district offices, and four separate letters to beneficiaries." Letter from Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Hum. Servs., to Christopher T. Sununu, Governor, Donna M. Soucy, President, N.H. Senate, & Steve Shurtleff, Speaker, N.H. House of Representatives 2 (July 8, 2019).[29] Teams of employees even "travelled door to door in selected locations in the [S]tate to speak with persons from whom" the State had "not received information." *Id.* But even these "considerable efforts" were ineffective. *Id.* at 3. New Hampshire's beneficiaries were still unaware that the new work and reporting requirements existed—much less how those requirements could be satisfied.

Such outreach and administrative obstacles are unavoidable. *New Hampshire's Experience*, *supra*, at 9. Beneficiaries are disproportionately "transient" and "highly mobile," changing their addresses and telephone numbers far more frequently than the greater population. *Lessons from Arkansas*, *supra*, at 7. Indeed, New Hampshire's door-to-door visits "resulted in in-person contact" with beneficiaries just 13 percent of the time. *New Hampshire's Experience*, *supra*, at 13. And the State, unavoidably, lacked "cell phone numbers and email addresses" for a large portion of its beneficiaries. *Id.* Even those who do not regularly change addresses or telephone numbers are in a "hard-to-reach population." *Id.* at 33. Nationally,

[29] https://bit.ly/3dE76Ym.

more than a quarter of Medicaid adults never use a computer and do not use the Internet, while 40 percent do not use e-mail. *Understanding the Intersection*, *supra*, at 9. Arkansas's and New Hampshire's failures show that it is impossible to fully inform beneficiaries of how to comply with a set of complex reporting requirements—leading to "the unintended loss of coverage for thousands of beneficiaries." Letter from Jeffrey A. Meyers, *supra*, at 3. That unavoidable consequence casts even more doubt on HHS's theory that work requirements will somehow preserve, let alone expand, healthcare coverage.

II. WORK REQUIREMENTS WILL MAKE BENEFICIARIES SICKER, NOT HEALTHIER.

As its second justification, HHS asserts that tying Medicaid to work will spread State resources further by "increas[ing]" the "health and wellness of beneficiaries." HHS Br. 33. It conjures up a chain of events where work requirements prompt non-working beneficiaries to find a job, which in turn makes them healthier, and thus "reduces the cost of providing them health-care coverage." *Id.* But that chain breaks at the first link: Most non-working beneficiaries will be unable to overcome enormous structural barriers and find a steady job. *Supra* pp. 9-15. Instead, work and reporting requirements will strip beneficiaries of coverage altogether. Long-term coverage loss will devastate their health. And even short-term gaps in coverage will lead to significantly worse health outcomes—and ultimately make beneficiaries *less* employable.

A. Depriving Beneficiaries Of Coverage Can Devastate Their Health.

With no increase in employment, Arkansas Works caused thousands of beneficiaries to lose coverage altogether. The percentage of uninsured 30- to 49-year-old Arkansans—those initially subject to the work and reporting requirements—increased "from 10.5% in 2016 to 14.5% in 2018," with smaller or no changes in other age groups. *Results from the First Year*, *supra*, at 1075; *see also Two-Year Impacts*, *supra*, at 1526. By contrast, the "insurance rate for adults ages 30-49" outside of Arkansas was "fairly stable" during this period. *Two-Year Impacts*, *supra*, at 1525. Work and reporting requirements cause mass disenrollment, which will make beneficiaries sicker.

Healthcare coverage is critical to positive health outcomes. *See, e.g.*, *Lessons from Arkansas*, *supra*, 24-25. *First*, coverage allows beneficiaries to receive preventative screening to detect debilitating or deadly diseases earlier. Beneficiaries newly enrolled after recent Medicaid eligibility expansions have proven more likely to screen for cervical, prostate, and breast cancer, as well as diabetes, hypercholesterolemia, and HIV. Benjamin D. Sommers et al., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 New England J. Med. 586, 588 (Aug. 10, 2017) (*Recent Evidence*).[30] Not surprisingly, those additional screenings created a "shift to early stage" diagnosis for cancer patients, improving their health and potentially saving their lives. Xuesong Han et al., *Comparison of Insurance Status and Diagnosis Stage Among Patients with Newly Diagnosed Cancer Before*

[30] https://bit.ly/2QQxvF6.

vs After Implementation of the Patient Protection and Affordable Care Act, 4 JAMA Oncology 1713, 1717 (2018).[31]

Those suffering from mental illness, in particular, benefit from preventative screenings. People with serious mental illness on average die 25 years earlier than the rest of the population—often from conditions that proper screenings would identify long before they become deadly. Barbara Mauer et al., Nat'l Ass'n of State Mental Health Program Dirs. (NASMHPD), Med. Dirs. Council, *Morbidity and Mortality in People with Serious Mental Illness* 4 (2006) (*Morbidity and Mortality*).[32]

Second, discontinuing coverage for patients who have been diagnosed with cancer or another life-threatening disease may be nothing short of catastrophic. For most of these patients, losing Medicaid means "forgoing their treatment altogether." Letter from Christopher W. Hansen, President, Cancer Action Network, Am. Cancer Soc'y to Tom Price, Sec'y, Dep't of Health & Hum. Servs. 2 (Aug. 3, 2017).[33] As a result, uninsured patients with cancer, diabetes, and heart disease have much worse survival rates than insured patients suffering from the same diseases. Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 Am. J. Health Econ. 392, 400 (2017).[34]

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[31] https://bit.ly/3skI3h9.

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

[33] https://bit.ly/3bC12go.

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

Moreover, many uninsured patients delay seeking even life-saving care for fear of prohibitive costs. Jennifer Tolbert et al., Kaiser Fam. Found., *Key Facts About the Uninsured Population* (Nov. 6, 2020).[35] Indeed, of Arkansas's more-than-18,000 recently disenrolled beneficiaries, "55.9 percent delayed needed care in the past year because of cost." *Two-Year Impacts*, *supra*, at 1527. For these reasons, among others, one life could be saved for every 250-300 people who enroll in healthcare coverage. *See, e.g.*, *Recent Evidence*, *supra*, at 590; *see also* Randall R. Bovbjerg & Jack Hadley, Urb. Inst., *Why Health Insurance Is Important* 1 (2007) ("Death risk appears to be 25 percent or higher for [uninsured] people with certain chronic conditions, which led to the [Institute of Medicine] estimate of some 18,000 extra deaths per year.").[36]

Third, negative health consequences of losing coverage fall particularly hard on women. Work exemptions for pregnant women are not enough; "[w]omen need regular [pre-conception] care to manage both acute and chronic conditions that could impact the health of future pregnancies." March of Dimes, *Medicaid, Work Requirements, and Maternal and Child Health* 1 (last visited Feb. 24, 2021).[37] Untreated preconception conditions like asthma, sexually transmitted infections, and thyroid disease can harm women's health, lead to birth defects, or trigger miscarriages. *See* Off. on Women's Health, U.S. Dep't of Health &

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[35] https://bit.ly/3si9vfB.

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

[37] https://bit.ly/2NRJkNZ.

Hum. Servs., *Pregnancy Complications* (last updated Apr. 19, 2019).[38]

Fourth, losing coverage negatively affects beneficiaries' mental health. For decades, research has shown that unemployed workers experience high rates of depression. *See, e.g.*, Margaret W. Linn et al., *Effects of Unemployment on Mental and Physical Health*, 75 Am. J. Pub. Health 502, 504 (1985).[39] That is especially apparent now, as the current economic and health crises have spurred increased symptoms of anxiety and depressive disorders. Mark É. Czeisler et al., Ctrs. for Disease Control & Prevention, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24 – 30, 2020*, 69 Morbidity & Mortality Wkly. Rep. 1049 (2020).[40]

Healthcare coverage is part of the solution. One study, for example, showed that increased access to mental-health treatment led to a 30 percent reduction in depression rates, even without accounting for increased access to and use of anti-depressants. Katherine Baicker et al., *The Oregon Experiment — Effects of Medicaid on Clinical Outcomes*, 368 New England J. Med. 1713, 1717 (May 2, 2013).[41] Another study across 10 Medicaid eligibility expansion States found that the previously uninsured with mental-health issues visited hospitals 44 percent less frequently after eligibility was expanded. *Medicaid's Role in*

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[38] https://bit.ly/2P1ziKx.

[39] https://bit.ly/37Fyce7.

[40] https://bit.ly/3qMM6T2.

[41] https://bit.ly/37GA0mO.

Behavioral Health, Henry J. Kaiser Fam. Found. (May 5, 2017).[42]

B. Even Short-Term Gaps In Coverage Cause Significantly Worse Health Outcomes And Make Beneficiaries Less Employable.

Many working beneficiaries will experience gaps in coverage for failing to meet work or reporting requirements in some months or years, even though they have steady jobs. *See supra* pp. 16-19. Others will be disenrolled only to later re-enroll once they become too ill to work, disabled, medically frail, pregnant, a parent to a dependent child, or meet another exemption. New Hampshire Amicus Br. 7-9 (quoting N.H. Rev. Stat. § 126-AA:2, III(d)(1-8)). Those coverage gaps will create significantly worse health outcomes and make it more difficult for beneficiaries to stay employed.

Even the short-term uninsured are consistently and significantly less healthy than the insured. Those who recently lost coverage are "two to three times as likely" to report health-care-access problems than those with consistent coverage, even "after controlling for income, health status, age, and sex." Cathy Schoen & Catherine DesRoches, *Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage*, 35 Health Servs. Rsch. 187, 203 (Apr. 2000) (*Uninsured and Unstably Insured*).[43] Such coverage interruptions lead to increased emergency room visits, hospitalizations, and admissions to mental-health facilities. Leighton Ku & Erika Steinmetz, Ass'n for

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

[43] https://bit.ly/3smQicB.

Cmty. Health Plans, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid* 1 (Sept. 10, 2013).[44] Forty-seven percent of patients who experience a coverage gap report that it hurt their overall health. Benjamin D. Sommers et al., *Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many*, 35 Health Affs. 1816, 1820 (2016) (*Insurance Churning*).[45]

Healthcare delivery breaks down for patients who lack continuous coverage. Many patients cannot afford to keep their primary care physician or see a specialist during a coverage gap. *Id.* One study calculated that patients with intermittent coverage were five times more likely to be priced out of seeing a doctor than those with consistent coverage. John Z. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 JAMA 2061, 2064–65 (2000) (*Unmet Health Needs*). That study also found that 21.7% of the short-term uninsured could not afford a needed doctor visit, compared to 26.8% of the long-term uninsured and 8.2% of those with coverage. *Id.* at 2066. These numbers "suggest[] that even short-term periods without insurance may cause sizeable numbers of people to forgo needed care." *Id.*

Intermittent coverage also diminishes access to potentially life-saving preventive screenings. Beneficiaries with coverage gaps are significantly less likely to get mammograms, Pap smears, or screening for hypertension or high cholesterol. *Id.* at 2065; *see also* Julia Foutz et al., Henry J. Kaiser Fam. Found., *The*

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[44] https://bit.ly/3kitloa.

[45] https://bit.ly/3bwlteF.

Uninsured: A Primer—Key Facts About Health Insurance and the Uninsured Under the Affordable Care Act 12 (Dec. 2017) ("Research has shown that adults who experience gaps in their health insurance coverage are less likely to * * * be up to date with blood pressure or cholesterol checks than those with continuous coverage.").[46]

Once those often-preventable conditions arise, coverage gaps make it far more difficult for patients to get the medication or other treatment they need. By some estimates, nearly half of all patients with sporadic coverage will forgo necessary medication during a coverage gap. *Insurance Churning*, *supra*, at 1820; *see also Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured*, Henry J. Kaiser Fam. Found. (Nov. 27, 2017) (stating those who need mental-health treatment are less likely to receive care during coverage gaps).[47] Conditions worsen as they go untreated, ultimately threatening the lives of those with intermittent coverage. Indeed, "[a] 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders." Letter from the Ctr. for L. & Soc. Pol'y to Alex Azar, Sec'y, U.S. Dep't of Health & Hum. Servs. 4 (Aug. 31, 2018).[48]

That is particularly problematic because Medicaid enrollees—even those with steady jobs—"have above average rates of chronic conditions." *Many Working*

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

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

[48] https://bit.ly/3aOTw2s.

People, *supra*, at 9. For example, more than half of *working* adults enrolled under Michigan's Medicaid eligibility expansion had a serious "[p]hysical health condition," such as heart disease, asthma, or diabetes, and 25.2% had a mental-health condition, often depression. Renuka Tipirneni et al., *Employment Status and Health Characteristics of Adults with Expanded Medicaid Coverage in Michigan*, 178 JAMA Internal Med. 564, 565 tbl.1 (Apr. 2018).[49] Temporarily depriving them of coverage if they fail to meet work requirements for a given period could devastate their health.

It could also leave them unemployed. Most low-wage jobs "offer little flexibility," with, for example, no sick leave. Ctr. for Budget & Pol'y Priorities, *Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers* 2 (updated Mar. 10, 2020) (*Taking Away Medicaid*).[50] The type of "health setbacks" caused by temporary coverage loss can therefore destroy a low-wage worker's job prospects, *id.*, particularly those seeking the "physically demanding" work most associated with Medicaid beneficiaries. *See supra* p. 11.

By that same token, continuous coverage makes it easier for beneficiaries to stay employed. For the many Medicaid enrollees with serious health conditions, coverage "provides access to needed treatments that allow them to control [prevalent health] conditions and maintain employment." *Taking Away Medicaid*, *supra*, at 2; *see also* MaryBeth Musumeci et al., Henry J. Kaiser Fam. Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives*

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[49] https://bit.ly/37EzEgQ.

[50] https://bit.ly/2NPpbYK.

of Enrollees 11 (Dec. 2018) (describing how access to "critical prescription drugs * * * helped to control chronic conditions [and] enabled [beneficiaries] to work").[51] Not surprisingly, one survey found that 69 percent of workers who received Medicaid under Michigan's eligibility expansion reported doing "better at work once they had health insurance." Renuka Tipirneni et al., Inst. for Healthcare Pol'y & Innovation, Univ. of Mich., *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (June 27, 2017).[52]

Finally, those with chronic mental illnesses need consistent treatment and reliable access to medication to successfully manage and ultimately overcome their conditions. *See Morbidity and Mortality*, *supra*, at 5-6. Here, a gap in coverage can be fatal: Barriers to accessing mental-health treatment is a risk factor for suicide. *See Suicide Prevention: Risk & Protective Factors*, Ctrs. for Disease Control & Prevention (last visited Feb. 24, 2021).[53]

Without continuous coverage, patients simply do not get the care they need, leading to worse health outcomes, fewer job prospects, and potential catastrophe.

III. COVERAGE GAPS AND ADDITIONAL ADMINISTRATIVE COSTS WILL WASTE STATES' RESOURCES.

Finally, Medicaid work requirements will *waste* State resources, not "free[] up" additional funds that could be used to expand coverage. HHS Br. 32.

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[51] https://bit.ly/3bx7ky3.

[52] https://bit.ly/2MjtZoV.

[53] https://bit.ly/3sqZRr7.

Programs tying Medicaid coverage to work will lead to increased administrative costs and a sicker patient population that States will later cover at greater expense.

To start, simply setting up and maintaining the administrative systems to track exemptions and verify compliance costs tens of millions of dollars—not to mention the outreach costs for educating beneficiaries about new requirements. *See, e.g.*, Misty Williams, *Medicaid Changes Require Tens of Millions in Upfront Costs*, Roll Call (Feb. 26, 2018) (noting that Kentucky's Medicaid work requirements program could cost $187 million in the first six months).[54] In Arkansas, implementing its Medicaid work requirements cost $26.1 million. *Two-Year Impacts*, *supra*, at 1529. Michigan, the third and final State to put Medicaid work requirements in place, spent $28 million on outreach and implementation before the requirements took effect in January 2020. *States' Experiences*, *supra*, at 5. And an additional $40 million was earmarked for the remainder of the year. *Id.*

Further, administering Medicaid work requirements demands even more resources to address the "churn" that the programs create. "Churning" is the costly pattern of short-term enrollment, disenrollment, and re-enrollment—a pattern that becomes more frequent with periodic eligibility determinations like those under Arkansas Works and Granite Advantage. Katherine Swartz et al., *Reducing Medicaid Churning: Extending Eligibility for Twelve Months or to End of Calendar Year Is Most Effective*, 34 Health

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

Affs. 1180, 1180 (2015) (*Extending Eligibility*).[55] Because even 46 percent of *working* beneficiaries are at risk of losing coverage for insufficient hours, disenrolling beneficiaries only to later re-enroll them will become a predictable—and expensive—pattern. *Many Working People*, *supra*, at 1, 5. The administrative costs to a State "of one person's churning one time (disenrolling and reenrolling) could be from $400 to $600," which, on average, would increase the cost of covering a non-disabled Medicaid beneficiary by over 10 percent. *Extending Eligibility*, *supra*, at 1181.

On top of those administrative costs, work requirements will result in States having to pay higher medical bills for services to its beneficiaries. As explained, work and reporting requirements cause coverage gaps on a massive scale. *See supra* p. 28. By stripping healthy patients of their coverage, States will end up caring for sicker—and therefore more costly—patients when they re-enroll.

Indeed, "[w]hen individuals delay seeking routine care due to gaps in coverage," their "unmet health needs * * * become exacerbated," which "increase[s the] costs for [S]tates associated with" caring for them. Anita Cardwell, Nat'l Acad. for State Health Pol'y, *Revisiting Churn: An Early Understanding of State-Level Health Coverage Transitions Under the ACA* 3 (Aug. 2016) (*Revisiting Churn*).[56] For example, a patient without a regular primary-care provider will tend "to overuse expensive sources of care like the ER or put off seeing a doctor until their health

[55] https://bit.ly/3aL2Xju.

[56] https://bit.ly/3kgGXjL.

deteriorates enough to warrant [a much more costly] inpatient episode." Ritesh Banerjee et al., *Impact of Discontinuity in Health Insurance on Resource Utilization*, 10 BMC Health Servs. Rsch. 1, 8 (2010).[57]

Moreover, because Medicaid coverage increases the availability of primary and preventive care, monthly Medicaid expenditures on average "decline the longer that [beneficiaries] are enrolled in the program." *Revisiting Churn*, *supra*, at 3. This pattern—putting off smaller bills today at the expense of paying larger bills tomorrow—will be repeated at scale when disenrolled beneficiaries regain benefits. Without continuous coverage, this population will be sicker and therefore more expensive for States to support in the long run. *See, e.g.*, David W. Baker et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 New England J. Med. 1106, 1108 (Oct. 11, 2011).[58]

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These significant costs yield no benefits. Work and reporting requirements do not increase employment or private coverage because practically all beneficiaries who can work do work. *See Results from the First Year*, *supra*, at 1079 (finding 95 percent of beneficiaries either are already working or qualify for an exemption); *Two-Year Impacts*, *supra*, at 1529 (same); *see also Barriers*, *supra*, at 3 (explaining that a high percentage of the beneficiary population qualifies for an exemption). Such requirements simply disenroll the remaining sliver of non-working beneficiaries, who face enormous obstacles to securing a job; part-time

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

[58] https://bit.ly/3pLDIlC.

workers who cannot receive more hours; and full-time or exempt workers who are unaware of how to properly report their time or basis for exemption. None of that preserves, let alone expands, coverage. This Court should reject HHS's baseless—and now refuted—theories.

CONCLUSION

For these reasons and those in Respondents' brief, this Court should affirm.

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