IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SAMUEL PHILBRICK, et al.,	)
	)
Plaintiffs,	)
	)
v.	) Civil Action No. 1:19-cv-00773 (JEB)
	)
ALEX M. AZAR II, et al.,	)
	)
Defendants.	)
	)

BRIEF OF THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS

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STATEMENT OF INTEREST OF AMICI

The American Academy of Pediatrics (AAP) is an organization of 67,000 pediatricians committed to protecting the well-being of America's children, including by engaging in broad and continuous efforts to prevent harm to the health of infants, children, adolescents, and young adults caused by a lack of access to health coverage and care.

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians, residents and medical students are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state, including in New Hampshire, and in every medical specialty.

This past November, NAMI filed the first version of this brief in the *Gresham* case (Doc. 36), and amici AMA and AAP joined NAMI in filing the second version of this brief in the *Stewart* case (Doc. 99) in January of this year.[1]

SUMMARY OF ARGUMENT

When New Hampshire implemented the Medicaid expansion, some 50,000 residents of New Hampshire got health coverage.

However, despite these gains, New Hampshire decided to change its system. After HHS issued guidance promoting imposing work requirements on people getting coverage through the

[1] By analogy to Fed R. App. P. 29(a)(4)(E): No party or counsel for a party authored this brief, in whole or in part, or contributed money to find the brief; and no one, other than the amici, their members, and their counsel, contributed money to find the brief.

Medicaid expansion, New Hampshire submitted an amended program that will take Medicaid coverage away from people who do not satisfy work requirements. This Court has already considered similar requirements as imposed on people in Kentucky and Arkansas.

As with respect to Kentucky and Arkansas, the claims are that work requirements will lift people out of unemployment, improve health outcomes, and strengthen the social safety net.

As with Kentucky and Arkansas, these claims are wrong.

Conditioning coverage on employment will lead to tens of thousands of disenrollments and health outcomes that will worsen over time. New Hampshire has not been forthright enough to make the projections that Kentucky most recently made – of more than a million lost coverage months – but the requirements it has sought to impose are more drastic than Kentucky's. Most of New Hampshire's unemployed beneficiaries are not just unemployed, but are unable to work at the levels demanded by the State. Those who are looking for work will not be helped in their job searches by losing health care that supports them as they search. Moreover, many low-income beneficiaries who do work do not have the kind of regular work schedules that tally easily into New Hampshire's tracking system. Nothing in New Hampshire's application, or HHS's approval, addresses these barriers. Looking at Kentucky, Arkansas, and New Hampshire's own experience with work requirements in the SNAP program, one can expect substantial losses of coverage. In turn, New Hampshire residents will get sicker; some will die prematurely.

Granite Advantage will require reporting that will be difficult for people to do, particularly when they experience mental illness and cognitive impairments. Reporting mistakes and failure to submit documentation at renewal times will lead to disenrollment. Appeal and reenrollment processes exist, but will be difficult for people with disabilities to invoke.

Granite Advantage will impose financial burdens not just on beneficiaries but on health providers and on the State. Losing benefits exposes former beneficiaries (and, given restrictions on retroactive coverage, sometimes even current beneficiaries) to the risk of medical bills they cannot afford and, in some cases, the risk of bankruptcy. Without a reliably insured patient population, rural providers will be forced to shut their doors. Meanwhile, Granite Advantage will increase the State's administrative burdens, as it tries to track people's attempts to work, and cost it federal matching funds that very substantially support each person who should be getting, but is not getting, coverage through the Medicaid expansion.

As with Kentucky and Arkansas, HHS's explanation for granting the New Hampshire waiver "runs counter to the evidence before the agency." *Motor Vehicle Manufacturers Ass'n of the U.S., Inc., v. State Farm Mutual Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). It should be set aside.

ARGUMENT

I. BY CAUSING THOUSANDS TO DISENROLL FROM MEDICAID, THE WORK REQUIREMENTS WILL LEAD TO FAR WORSE HEALTH OUTCOMES.

A. Granite Advantage Will Strip Thousands of Their Health Coverage.

In contrast to Kentucky, New Hampshire does not project any Medicaid coverage losses over the five-year period of the waiver. That failure to project losses does not match up with the actual facts. Specifically with respect to New Hampshire, a recent study projects that between 30 and 45 percent of the 51,000 low-income adults subject to the New Hampshire work requirement will likely be terminated within one year, "because they either can't meet the work requirements or have difficulty completing the necessary paperwork." Leighton Ku and Erin Brantley, "New Hampshire's Medicaid Work Requirements Could Cause More than 15,000 to

Lose Coverage," Commonwealth Fund, May 9, 2019.[2] This would mean coverage losses for between 15,000 and 23,000 people. *Id.*

Comparing New Hampshire and a prior study of Kentucky, Ku and Brantley "expect New Hampshire's losses will be higher because its work requirements are stricter than those planned for Kentucky. New Hampshire will terminate those who work less than 100 hours per month, while Kentucky used an 80-hour limit." *Id.*

Additionally, "New Hampshire [has] adopted policies harsher than those used in Arkansas, which limited the policies to adults up to the age of 49 without children and waited three months prior to termination. In contrast, New Hampshire exempts one parent of a child under 6 or a disabled child." *Id.*[3]

While the State has claimed there will be no enrollment losses over a five-year period, that contradicts New Hampshire's own recent experience with SNAP work requirements, where in 2012-13 the SNAP caseload went down by about five percent in New Hampshire in contrast to other New England states, where it rose moderately. *Id.*

New Hampshire's claims also contradict what is most obviously known about who is unemployed in New Hampshire and what sorts of opportunities they need.

As the Urban Institute's analysis of Arkansas work requirements shows, most non-working, non-exempt Medicaid beneficiaries have exited the labor force altogether. Anuj

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

[3] The New Hampshire Fiscal Policy Institute has collected information about coverage losses in other states and attempted to scale those studies to New Hampshire, noting in a table the reasons why New Hampshire's work requirements are more drastic than requirements in other states. NHFPI Issue Brief, "Medicaid Work Requirements and Coverage Losses," May 20, 2019, available at http://nhfpi.org/wp-content/uploads/2019/05/Issue-Brief-Medicaid-Work-Requirements-and-Coverage-Losses.pdf.

Gangopadhyaya et al, Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know About Them (Urban Institute, May 2018)[4] ("Urban Institute Arkansas"). These beneficiaries often have health conditions that limit their ability to work; are disproportionately unskilled and uneducated; and live in economically depressed parts of the State. Yet HHS and New Hampshire have disregarded the unusually high barriers this population faces in securing employment.

First, the Urban Institute's analysis of Arkansas work requirements indicates that more than one-third of unemployed beneficiaries subject to the work requirement have at least one serious health limitation; one-fifth report two or more. This group may not qualify as disabled for Supplemental Security Income (SSI) or Medicaid 209(b) purposes, but may nonetheless be unable to work. And, although New Hampshire exempts the "medically frail" from its new work requirements, as CMS has advised, the vague and general definition of this term leaves many important questions open. For example, it is unclear whether the definition of "medically frail" includes cancer survivors. Many non-working, non-exempt Medicaid beneficiaries have physical limitations that make it difficult to do everyday tasks, such as walking, climbing stairs, and running errands. Even under the most generous definition of "medically frail," however, thousands will fall through the cracks and be deprived of coverage. For these beneficiaries, the same health limitations that bar them from the workforce prevent them from meeting the community engagement requirement by volunteering or going through job training.

People suffering from mental illness face particular challenges. Thousands of people not formally listed as disabled have intellectual or mental-health challenges that make it difficult for

[4] Available at https://www.urban.org/sites/default/files/publication/98483/2001846_2018.05.23_arkansas_medicaid_finalized.pdf

them to 'concentrat[e], remember[], or mak[e] decisions.' Urban Institute Arkansas at 17. Moreover, because mental illness is "characterized by remission and relapse," Yoichiro Takayanagi et al. Accuracy of Reports of Lifetime Mental and Physical Disorders: Results from the Baltimore Epidemiological Catchment Area Study, (JAMA, March 2014),[5] beneficiaries could be in a state of recovery at the time they are assessed to see if they are "medically frail," meaning that when and if their health deteriorates they would find it difficult to hold down a job and continue to receive health insurance.

Second, New Hampshire's non-working, non-exempt beneficiaries face even higher barriers to employment due to a lack of education and skills. Federal Reserve, A Perspective from Main Street: Long-Term Unemployment and Workforce Development (December 2012).[6] A majority of this group in Arkansas has no education beyond high school, while roughly 25% has less than that. Urban Institute Arkansas at 13. Because "a high percentage of [open jobs] require higher education or specialized training," uneducated workers face the highest hurdles in finding work. Id. at 5. Compounding these issues, finding work becomes more difficult the longer a beneficiary is unemployed, because "skills atrophy, networks erode, and personal barriers to re-employment" increase once a worker exits the workforce. Rockefeller Foundation, Long-Term Unemployment (May 2013),[7]

But even those lucky enough to have a job are not safe. Granite Advantage threatens to disenroll tens of thousands of working New Hampshire residents from Medicaid. In order to maintain coverage throughout the years, Granite Advantage requires that enrollees work 100 hours

[5] Available at https://www.ncbi.nlm.nih.gov/pubmed/24402003.
[6] Available at https://www.federalreserve.gov/consumerscommunities/files/Workforce_errata_final2.pdf.
[7] Available at https://assets.rockefellerfoundation.org/app/uploads/20130528215222/Long-Term-Unemployment.pdf.

per month. This framework does not seem to reflect the reality of many beneficiaries' work lives. Many New Hampshire Medicaid beneficiaries work at least 1200 hours per year, but do not do this over 12 full months weeks. Another group of workers do not clock 1200 hours annually. This is not for lack of trying. Hours are nearly always outside the control of the worker: "For example, poor sales may result in retail workers being called in for fewer hours than scheduled." Jessica Gehr, Policy Brief: Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers (CLASP, June 2017).[8] And, given the uncertainty of part-time schedules, it will be difficult for beneficiaries to make up for lost hours by volunteering or training. *Id.*

Plaintiff Samuel Philbrick, for example, works variable hours per week at a sporting goods store. His work schedule is up to his manager, and there are times when he works only 16 hours per week. He needs Medicaid-funded medications in order to be sleep well enough to work such a varied schedule. Declaration of Samuel Philbrick, May 6, 2019 (Exhibit A). Plaintiff Ian Ludders works seasonally, pruning trees and picking apples, and doing other jobs, and "[t]he hours vary depending on the needs of the various farms or orchards, and the weather. There are often months where I do not work 100 hours, particularly when I am between paid jobs. Declaration of Ian Ludders, May 3, 2019 (Exhibit B). Plaintiffs Karin and Josh VLK have physical issues – back trouble in her case, a hernia in his – that make it hard to do physical labor, and both have mental health issues that lead to difficulties in keeping track of and presenting paperwork. Without Medicaid, according to his declaration, she would not be able to get back surgery, he would not be able to get treatment for his hernia, and neither would get medically necessary medications. He has been told that he'll have an exemption by analogy to New Hampshire's SNAP program, but is

[8] Available at https://www.clasp.org/sites/default/files/publications/2017/08/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf.

not sure what that means or how to maintain the exemption. Affidavits, May 8, 2019 (Exhibits C and D).

The large majority of both working and non-working beneficiaries who lose Medicaid will lose their health coverage altogether. The majority of New Hampshire's non-working population lacks the means to obtain commercial coverage – a large number of this population is below the federal poverty level, and is therefore ineligible for federal subsidies available for health insurance through the health insurance exchanges, 26 U.S.C. § 36B and 42 U.S.C. § 18071. Most working beneficiaries earn just enough to be ineligible for subsidies, but are not eligible for employer-sponsored insurance either. Imposing a work requirement will simply push these beneficiaries into the ranks of the long-term uninsured.

It will also risk the continued coverage of these beneficiaries' children. Many non-exempt enrollees have children under the age of 18. The health coverage of a parent and child is closely intertwined: when parents lose coverage, so do their children.

In sum, the new New Hampshire system will not meaningfully "encourage" beneficiaries to "attain or retain financial independence." Thinly veiled threats, or "incentives," will not help beneficiaries enter the workforce or obtain steadier employment. Thousands of Medicaid beneficiaries cannot work as a medical matter, face serious difficulties in finding employment, or work too inconsistently to meet the work requirement. Holding health coverage hostage will only exacerbate these problems.

B. Losing Medicaid and health insurance coverage leads people to die or live with untreated and more serious chronic conditions.

Depriving beneficiaries of coverage can devastate their health. When New Hampshire expanded Medicaid eligibility, the uninsured rate for the low-income population dropped from 10.7% in 2013 to 5.8% in 2017. New Hampshire Insurance Department, "2017 Final Report of

the Health Care Premium and Claims Cost Drivers (December 2017).[9] In the first years of the expansion, 25,800 people received wellness checkups, 10,500 people received cervical cancer screenings, 6,600 people were screened for breast cancer, and 4,700 people were screened for colorectal cancer. 41,600 people received mental health treatment, and 11,000 people received treatment for substance use disorders. New Hampshire DHHS, New Hampshire Health Protection Program, September 27, 2017.[10] Granite Advantage reverses course. Some may die prematurely as a result. Indeed, one life is saved for approximately every 250-300 people who gain coverage. Benjamin D. Sommers, Atul A. Gawande, and Katherine Baicker, Health Insurance Coverage and Health – What the Recent Evidence Tells Us, NEJM August 10, 2017. (Sommers, "Recent Evidence")[11]; Randall R. Bovbjerg and Jack Hadley, While Health Insurance is Important (Urban Institute, November 2007),[12] ("Death risk appears to be 25 percent or higher for [uninsured] people with certain chronic conditions, which lead to the [Institute of Medicine]" estimate of some 18,000 extra deaths per year").

Rolling back Medicaid eligibility places the thousands of New Hampshire residents who rely on the program for the prevention and early detection of life-threatening diseases in peril. Leighton Ku et al, Medicaid's Role in Providing Preventive Care for Adults (Kaiser, May 17, 2017) (Ku, "Preventive Care").[13] Preventive services enable early intervention, which can prevent, delay, or minimize the effects of often fatal diseases and conditions. See, e.g., Todd P. Gilmer and

[9] Available at https://ww.nh.gov/insurance/reports/documents/2018-nhid-annual-hearing-final-report.
[10] Available at https://www.dhhs.nh.gov/ombp/pap/documents/dhhs-pap.pdf.
[11] Available at https://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645.
[12] Available at https://www.urban.org/sites/default/files/publication/46826/411569-Why-Health-Insurance-Is-Important.PDF.
[13] Available at http://files.kff.org/attachment/Data-Note-Medicaids-Role-in-Providing-Access-to-Preventive-Care-for-Adults.

Patrick J. O'Connor, The Growing Importance of Diabetes Screening, Diabetes Care (July 2010).[14] Preventive services are especially important for Medicaid-eligible adults, because they have "significantly higher rates of chronic conditions and risky health behaviors that may be amenable to preventive care" than other adults. Ku, Preventive Care.

An analysis of Medicaid expansion and drug prescriptions shows that states that expanded Medicaid in 2014, like New Hampshire, prescriptions for opioid addiction therapies went up dramatically, as compared with states that had not expanded Medicaid by 2016. Benjamin A.Y. Cher et al, Medicaid Expansion and Prescription Trends: Opioids, Addiction Therapies, and Other Drugs, 57 Medical Care 208 (March 2019), figure 1.[15]

Those suffering from mental illness would also benefit tremendously from these types of preventive screenings. People with serious mental illness on average die 25 years earlier than the rest of the population. National Ass'n of State Mental Health Program Directors, Morbidity and Mortality in People with Serious Mental Illness (Oct. 2006).[16] About 60% of these deaths are due to conditions such as "cardiovascular, pulmonary and infectious diseases" that could be identified and treated if the proper screenings were conducted. *Id.* at 5.

Moreover, discontinuing coverage for patients who have already been diagnosed with cancer or another chronic disease can be nothing short of catastrophic. Thousands of New Hampshire residents rely on Medicaid for treatment of these conditions. Indeed, in Arkansas and Kentucky, on initial Medicaid expansion, there was a better than 10% increase in individuals with chronic conditions getting regular care as compared with Texas, a state that didn't initially expand

[14] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2890385/pdf/zdc1695.pdf.
[15] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6375792/pdf/mlr-57-208.pdf.
[16] Available at https://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

Medicaid. ASPE Issue Brief: Medicaid Expansion Impacts on Insurance Coverage and Access to Care (Jan. 18, 2017). This care saves lives. Uninsured patients with cancer, diabetes, and heart disease have much worse survival rates than insured patients suffering from the same diseases. Rolling back Medicaid eligibility reverses these gains and exposes many chronically ill individuals to a higher chance of premature death.

In addition, depriving New Hampshire residents of coverage will reverse the increases in access to primary care, ambulatory-care visits, and use of prescription medications resulting from New Hampshire's eligibility expansion. Sommers, Recent Evidence. Successfully treating hypertension – thereby reducing the risk of heart disease – depends on reliable access to prescription drugs. HHS, Improving Medication Adherence Among Patients with Hypertension (Feb. 2017).[17] The same is true of chronic mental illnesses, NAMI California, Types of Mental Illness,[18] and diabetes. Granite Advantage will strip non-working beneficiaries – often those who face the highest risk of developing chronic conditions – of the medication and other treatment they need to live healthy and secure lives.

Lower-income adults have higher rates of both hypertension and diabetes. Amy Z. Fan, Sheryl M. Strasser, Xingyou Zhang, Jing Fang, and Carol G. Crawford, State Socioeconomic Indicators and Self-Reported Hypertension Among US Adults, 2011 Behavioral Risk Factor Surveillance System (CDC, February 26, 2015),[19] and Sharon H. Saydah, Giuseppina Imperatore, and Gloria L. Beckles, Socioeconomic Status and Mortality: Contribution of health care access and psychological distress among U.S. adults with diagnosed diabetes, 36 Diabetes Care 49 (Jan.

[17] Available at https://millionhearts.hhs.gov/files/TipSheet_HCP_MedAdherence.pdf.
[18] Available at https://www.naminh.org/resources-2/fact-sheets.
[19] Available at https://www.cdc.gov/pcd/issues/2015/pdf/14_0353.pdf.

2013).[20] Losing coverage also negatively impacts beneficiaries' mental health. People who are unemployed already experience high rates of depression. Margaret W. Linn, Richard Sandifer, and Shayna Stein, Effects of Unemployment on Mental and Physical Health, 75 Am. Journal of Public Health 502 (1985).[21]

Medicaid helps these individuals get the treatment they need. For example, 44% of Ohio Medicaid eligibility expansion enrollees diagnosed with mental health conditions reported that access to mental health treatment became easier after enrolling in Medicaid. Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly ("Ohio Report").[22] Another study showed that increased access led to a 30% reduction in depression rates, even without accounting for increased access to and use of anti-depressants. Katherine Baicker et al, The Oregon Experiment – Effects of Medicaid on Clinical Outcomes, 368 NEJM 1713 (May 2, 2013).[23] Depriving these individuals of this effective source of care risks exacerbating their mental health conditions because, without insurance, they will be far less likely to receive the mental health treatment they need. Sommers, "Recent Evidence," at 588.

The negative health consequences of losing coverage fall particularly hard on women. Granite Advantage's exception for pregnant women is not enough: "[w]omen need regular [pre-conception] are 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

[20] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3526248/pdf/49.pdf.

[21] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1646287/pdf/amjph00281-0056.pdf.

[22] Available at https://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf.

[23] Available at https://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321?articleTools=true.

(April 2018).[24] Indeed, pre-conception conditions such as asthma, sexually transmitted infections, and thyroid disease, if left untreated, could harm a woman's health, lead to birth defects, or even trigger miscarriages. CDC, Pregnancy Complications (June 6, 2018).[25] Granite Advantage exacerbates these risks, because [nearly one-third] of the women of reproductive age in the State get their health coverage through Medicaid. Guttmacher Institute, Gains in Insurance Coverage for Reproductive-Age Women at a Crossroads (Dec. 4, 2018).[26]

The children of parents who lose coverage will also likely suffer negative health outcomes. "A recent study showed that increases in adult Medicaid eligibility levels were associated with a greater likelihood that children in low-income families received at least 1 annual well child visit." These "visits serve as the primary platform for delivery of preventive services to children, and children who receive these visits are more likely to complete immunization schedules and are less likely to have avoidable hospitalizations." American Academy of Pediatrics, Parental Medicaid Expansions Can Have a Spillover Effect on Children's Health Use (Nov. 2017).[27] Finally, the dangers of losing health coverage are especially acute for the near-elderly, David W. Baker, Lack of Health Insurance and Decline in Overall Health in Late Middle Age, NEJM (Oct. 11, 2011)[28] -- a segment of the population disproportionately likely to lose Medicaid benefits under Granite Advantage. Age is a powerful risk factor for many diseases, including heart disease and cancer. Further, "more than seven in ten 50- to 64-year-olds report having been diagnosed with one or

[24] Available at https://www.marchofdimes.org/materials/Medicaid-work-requirements-IB-March-of-Dimes-April2018.pdf.
[25] Available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-complications.html.
[26] Available at https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.
[27] Available at https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Parental-Medicaid-Expansions-Can-Have-a-Spillover-Effect-on-Children%27s-Health-Use.aspx.
[28] Available at https://www.nejm.org/doi/pdf/10.1056/NEJMsa002887?articleTools=true.

more chronic health conditions, and nearly half have two or more chronic conditions." Gerry Smolka, Megan Multack, and Carlos Figuieredo, Health Insurance Coverage for 50- to 64-year-olds (AARP, Feb. 2012).[29]

Health insurance is particularly important for this group – the uninsured near-elderly are 63% more likely than their privately insured peers to see a decline in their overall health and 23% more likely to have a new physical difficulty that affects walking or climbing stairs. Baker at 1108.

HHS and New Hampshire ignore the mountain of evidence showing that eliminating coverage makes beneficiaries sicker. Handcuffing Medicaid eligibility to employment will lead to worse health outcomes.

II. ELIMINATING RETROACTIVE ELIGIBILITY FOR MEDICAID WILL CONFIRM AND WORSEN COVERAGE GAPS THAT ARE BAD FOR PEOPLE'S HEALTH AND SECURITY.

Periodic gaps in coverage trigger a cascade of negative health effects. Even the short-term uninsured are consistently and significantly less healthy than the insured. Indeed, those who lose insurance recently are "two or three times as likely to" report health-care-access problems than those without gaps in coverage, even "after controlling for income, health status, age, and sex." Cathy Schoen and Catherine M. DesRoches, Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage (Commonwealth Fund, April 1, 2000).[30] 47% of patients who experience a coverage gap report that it hurt their overall health. Benjamin D. Sommers, Rebecca Gourevitch, Bethany Maylone, Robert J. Blendon et al, Insurance Churning Rates for Low-Income

[29] Available at https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/Health-Insurance-Coverage-for-50-64-year-olds-insight-AARP-ppi-health.pdf.
[30] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089095/pdf/hsresearch00009-0024.pdf.

Adults Under Health Reform: Lower Than Expected But Still Harmful For Many (October 2016).[31]

Health-care delivery simply 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. Sommers at 1820. One study calculated that patients with intermittent coverage were five times more likely to be priced out of seeing a doctor than those with consistent coverage. John Z. Ayanian, JS Weissman, EC Schneider, ... Unmet health needs of uninsured adults in the United States, JAMA (Oct. 25, 2000).[32] That study also found that 21.7% of the short-term uninsured could not afford a needed doctor visit, compared to 26.8% of the long-term uninsured and 8.2% of those with coverage. Id. at 2066. These numbers "suggest[] that even short-term periods without insurance may cause sizable numbers of people to forego needed care." *Id.*

Intermittent coverage also diminishes access to potentially life-saving preventive screenings. Beneficiaries with coverage gaps are significantly less likely to get mammograms, Pap smears, or screening for hypertension and high cholesterol. Ayanian at 2065; see also Julia Foutz et al, The Uninsured, A Primer (December 2017)[33] ("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.")

Then, 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.

[31] Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455.
[32] Available at https://jamanetwork.com/journals/jama/fullarticle/193207.
[33] Available at http://files.kff.org/attachment/Report-The-Uninsured-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-Under-the-Affordable-Care-Act.

Sommers at 1820; see also Kaiser, Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured (Nov. 27, 2017)[34] (stating those who need mental health treatment are less likely to receive care during coverage gaps). Similarly, the short-term uninsured who smoke, are obese, or who have hypertension, diabetes, or elevated cholesterol are significantly more likely to be priced out of seeing a physician and unable to access medication than patients with continuous coverage. Ayanian at 2065, 2067. Finally, as conditions go untreated, they worsen, ultimately threatening the health and lives of those with intermittent coverage.

III. PEOPLE'S LOSING MEDICAID AND HEALTH INSURANCE COVERAGE WILL HURT PATIENTS, HOSPITALS, CLINICS, THE LONG-TERM CARE SYSTEM, AND THE STATE OF NEW HAMPSHIRE'S SAFETY NET.

In addition to generating worse health outcomes, Granite Advantage places undue pressure on all stakeholders. It will increase unemployment and bankruptcy rates for patients, while potentially forcing community providers and hospitals to shut down or limit services. Meanwhile, the State will be faced with increased administrative costs and a sicker patient population that it will later cover at greater expense. Patients face the most immediate financial challenges. "There is abundant evidence that having health insurance improves financial security," in part by "reduc[ing] bill collections and bankruptcies." Sommers, "Recent Evidence," at 586. Study after study shows that "decreased risk of out-of-pocket medical expenditures and debt for those who are newly eligible and take up Medicaid" triggers a chain of events resulting in improved financial outcomes for beneficiaries. Kyle J. Caswell and Timothy A. Waidmann, The Affordable Care Act Medicaid Expansions and Personal Finance, Medical Care Research and Review (Sage, 2017).[35]

[34] Available at http://files.kff.org/attachment/Fact-Sheet-Facilitating-Access-to-Mental-Health-Services-A-Look-at-Medicaid-Private-Insurance-and-the-Uninsured.
[35] Available at https://journals.sagepub.com/doi/pdf/10.1177/1077558717725164.

Medicaid coverage also decreases the risk of unemployment. For those who are working, Medicaid coverage makes it easier to hold down their jobs. See, e.g., Ohio Report at 4; Kara Gavin, Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches (June 27, 2017).[36] For those who do not have a job, Medicaid coverage makes it easier to find one. Ohio Report at 4.

Granite Advantage, by contrast, reinforces a vicious cycle. The long-term unemployed are not working in part because they lack coverage, but they cannot obtain coverage because they are not working. This cycle is likely disproportionately to affect New Hampshire residents experiencing mental illnesses: Roughly 80% of those served by public mental health authorities from 2016 to 2017 were unemployed. SAMHSA, New Hampshire 2016.[37]

Providers, too, will face increased financial strain. "Safety-net providers – consisting of publicly and privately supported hospitals, community health centers, local health departments, and other providers that care for a disproportionate share of vulnerable populations" – are an essential source of care for both the publicly insured and the uninsured. Suhui Li et al, Private Safety-Net Clinics: Effects of Financial Pressures and Community Characteristics on Closures, NBER Working Paper Series (October 2015).[38] But they face "constant threats from increasingly difficult financial conditions." *Id.* Medicaid and its associated revenues provide a partial solution. *Id.* at 5. Indeed, increased eligibility for Medicaid coverage is associated with "substantially lower likelihoods of [hospital] closure." Richard C. Lindrooth, et al, Understanding the Relationship Between Medicaid Expansions and Hospital Closures, Health Affairs (Jan. 2018).[39]

[36] Available at https://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches.
[37] Available at https://www.samhsa.gov/data/sites/default/files/NewHampshire-2016.pdf.
[38] Available at https://www.nber.org/papers/w21648.pdf.
[39] Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976.

But the reverse is also true. A plan that rolls back eligibility for Medicaid coverage could "lead to particularly large increases in rural hospital closures," *id.*, where needs are the greatest. These hospital closures would decrease access to primary, specialty, and emergency care, resulting in far worse health outcomes for both the insured and the uninsured. See, e.g., Institute of Medicine, Report Brief: America's Uninsured Crisis (Feb. 23, 2009).[40]

Finally, Granite Advantage will increase certain government expenditures. It will be necessary to set up an administrative system to track and verify exemptions – perhaps costing millions of dollars. See, e.g., Misty Williams, Medicaid Changes Require Tens of Millions in Upfront Costs, Roll Call, Feb. 26, 2018[41] (noting that Kentucky's Medicaid work requirement program could cost $187 million in the first six months). Further, administering Medicaid will now be more expensive for the State because more taxpayer dollars must address the 'churn' the plan creates. "Churning" is the costly pattern of short-term enrollment, disenrollment, and re-enrollment, which becomes more frequent with monthly eligibility determinations. Katherine Swartz, Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End of Calendar Year is Most Effective, Health Affairs (July 2015).[42]

. 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 enrollee by over 10%. Id. at 1181.

On top of those additional administrative costs, the State will now in many cases have to pay higher medical bills for the services provided to its beneficiaries. By stripping healthy patients

[40] Available at https://www.nap.edu/catalog/12511/americas-uninsured-crisis-consequences-for-health-and-health-care.
[41] Available at https://www.rollcall.com/news/politics/medicaid-kentucky.
[42] Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1204.

of their coverage, the State will end up caring for sicker and therefore more-costly patients down the road when they re-enroll. Indeed, "[w]hen individuals delay seeking routine care due to gaps in coverage," their "unmet health needs ... become exacerbated," which "increase[s the] costs associated with" caring for them. Anita Cardwell, Revisiting Churn: An Early Understanding of State-Level Health Coverage Transitions Under the ACA (August 2016).[43] For example, a patient without a regular primary-care provider will tend "to overuse expensive sources of care like the ER or put off seeing a doctor until their health deteriorates enough to warrant [a much more costly] inpatient episode." Ritesh Banderjee, et al, Impact of discontinuity in health insurance on resource utilization, (July 6, 2010).[44] Moreover, because Medicaid coverage increases the availability of primary and preventive care, monthly Medicaid expenditures on average "decline the longer that [recipients] are enrolled in the program." Cardwell at 3. This pattern – putting off small bills today at the expense of paying larger bills tomorrow – will be repeated at scale when disenrolled beneficiaries regain benefits through a successful appeal from a termination or new eligibility for an exemption. Without continuous coverage, this population will be sicker and therefore more expensive for the State to support in the long run. See, e.g., David W. Baker, Lack of Health Insurance and Decline in Overall Health in Late Middle Age, NEJM (Oct. 11, 2011).[45]

So Granite Advantage will not just harm beneficiaries' health; it will also harm New Hampshire people and safety net institutions' financial health.

[43] Available at https://nashp.org/wp-content/uploads/2016/08/Churn-Brief.pdf.
[44] Available at https://www.ncbi.nlm.nih.gov/pubmed/20604965.
[45] Available at https://www.nejm.org/doi/pdf/10.1056/NEJMsa002887?articleTools=true.

CONCLUSION

HHS and New Hampshire have disregarded ample evidence that shows Granite Advantage will not achieve its stated goals. It will not effectively improve health outcomes, lead to greater independence, or improve continuity of care. Cf. Approval Letter at 4. Instead, the work requirement rules, along with the new reporting requirements, will simply increase the numbers of the short- and long-term uninsured. HHS and New Hampshire have never accounted for how this loss of coverage will produce dramatically worse health outcomes. In approving Granite Advantage despite these deficiencies, HHS "entirely failed to consider an important aspect of the problem. *Motor Vehicle Manufacturers v. State Farm*, 463 U.S. 29 at 43. Moreover, in determining that Granite Advantage will "improve health outcomes" for Medicaid beneficiaries," HHS's decision ran "counter to the evidence" before it. *Id.* The Court should vacate HHS's approval of Granite Advantage and prevent the severe harms that its continuation will inflict on New Hampshire Medicaid beneficiaries.

Dated: May 28, 2019

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