NOT YET SCHEDULED FOR ORAL ARGUMENT

United States Court of Appeals for the District of Columbia Circuit

Nos. 19-5094 & 19-5096 (Gresham)
Nos. 19-5095 & 19-5097 (Stewart)

CHARLES GRESHAM, *et al.*,

Plaintiffs-Appellees,

v.

ALEX MICHAEL AZAR, II, Secretary of Health and Human Services, *et al.*,

Defendants-Appellants,

STATE OF ARKANSAS,

Intervenor for Defendants-Appellants.

RONNIE MAURICE STEWART, *et al.*,

Plaintiffs-Appellees,

v.

ALEX MICHAEL AZAR, II, Secretary of Health and Human Services, *et al.*,

Defendants-Appellants,

COMMONWEALTH OF KENTUCKY, *ex rel.* Matthew G. Bevin, Governor,

Intervenor for Defendants-Appellants.

KENTUCKY HOSPITAL ASSOCIATION,

Amicus Curiae for Appellants.

On Appeal from the United States District Court for the District of Columbia in Case Nos. 1:18-cv-152 and 1:18-cv-1900

BRIEF OF THE LAWYERS' COMMITTEE FOR CIVIL RIGHTS UNDER LAW AND THE NATIONAL WOMEN'S LAW CENTER AS *AMICI CURIAE* IN SUPPORT OF APPELLEES AND AFFIRMANCE

(For List of Appearances See Inside Cover)

June 27, 2019

JON GREENBAUM
DORIAN SPENCE
MARYUM JORDAN
LAWYERS' COMMITTEE FOR
CIVIL RIGHTS UNDER LAW
1500 K Street N.W., Suite 900
Washington, D.C. 20005
Tel.: (202) 662-8600
Fax: (202) 783-0857
jgreenbaum@lawyerscommittee.org
dspence@lawyerscommittee.org
mjordan@lawyerscommittee.org

GRETCHEN BORCHELT
SUNU CHANDY
MARA GANDAL-POWERS
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle, N.W., Suite 800
Washington, D.C. 20036
Tel.: (202) 588-5180
Fax: (202) 588-5185
gborchelt@nwlc.org
mgandal-powers@nwlc.org

JUDITH R. NEMSICK
CAITLIN L. STACHON
HOLLAND & KNIGHT LLP
31 West 52nd Street, 12th Floor
New York, New York 10019
Tel.: (212) 513-3200
Fax: (212) 385-9010
judy.nemsick@hklaw.com
caitlin.stachon@hklaw.com

CHRISTOPHER N. BELLOWS
HOLLAND & KNIGHT LLP
701 Brickell Avenue, Suite 3300
Miami, Florida 33131
Tel.: (305) 374-8500
Fax: (305) 789-7799
christopher.bellows@hklaw.com

Counsel for Amici Curiae

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

A. Parties and *Amici*. All parties, intervenors, and *amici* appearing before the district court and in this Court are listed in the Brief of Federal Defendants-Appellants. The Kentucky Hospital Association also appears as amicus curiae in *Stewart, et al. v. Azar, et al*., Nos. 19-5095 & 19-5057.

B. Ruling Under Review. References to the rulings at issue appear in Brief of Federal Defendants-Appellants.

C. Related Cases. The only related cases of which counsel is aware are identified in Brief of Federal Defendants-Appellants.

/s/ Judith R. Nemsick
Judith R. Nemsick

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Rule 26.1 of the D.C. Circuit, counsel for *amici curiae* certifies that the Lawyers' Committee For Civil Rights Under Law and the National Women's Law Center are not publicly held corporations, do not have parent corporations, and no publicly held corporation owns 10 percent or more of their stock.

/s/ Judith R. Nemsick
Judith R. Nemsick

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes

Other Authorities

GLOSSARY OF TERMS

ACA	Patient Protection and Affordable Care Act
Act	Social Security Act
Arkansas	State of Arkansas
AWA	Arkansas Works Amendments
CMS	Centers for Medicare and Medicaid Services
HHS	United States Department of Health and Human Services
Kentucky	Commonwealth of Kentucky
Kentucky HEALTH	Kentucky Helping to Engage and Achieve Long Term Health
Secretary	Secretary of United States Department of Health and Human Services
TANF	Temporary Assistance for Needy Families

STATUTES AND REGULATIONS

All pertinent statutes are contained in the Brief of Plaintiffs-Appellees.

IDENTITY AND INTERESTS OF *AMICI CURIAE*[1]

The Lawyers' Committee for Civil Rights Under Law ("Lawyers' Committee") is a nonpartisan, nonprofit organization that was formed in 1963 at the request of President John F. Kennedy to enlist the private bar's leadership and resources in combating racial discrimination and vindicating the civil rights of African-Americans and other racial minorities. The Lawyers' Committee's principal mission is to secure equal justice for all through rule of law and the organization frequently participates as *amicus curiae* to protect the interests of racial and ethnic minorities. *See, e.g., Benisek v. Lamone*, 138 S. Ct. 1942 (2018); *Gill v. Whitford*, 138 S. Ct. 1916 (2018); *Bethune-Hill v. Va. State Bd. of Elecs*., 137 S. Ct. 788 (2017); *Evenwel v. Abbott*, 136 S. Ct. 1120 (2016); *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Comm'n*, 138 S. Ct. 1719 (2018). The Lawyers' Committee has a strong interest in eliminating systemic and structural barriers to healthcare coverage, including access to reproductive health experienced by people of color, and to that end has served as *amicus curiae* in relevant cases. *See, e.g.*, *Pennsylvania v. Trump et al.*, 351 F. Supp. 3d 791 (E.D. Pa. 2019), *appeal filed*, No. 19-1189 (3d Cir. Jan. 23, 2019).

---

[1] No party's counsel authored this brief in whole or in part. No party or party's counsel made a monetary contribution intended to fund the preparation or submission of this brief, and no person other than *amicus curiae* funded the preparation of this brief. All parties have consented to the filing of this brief.

The National Women's Law Center ("Law Center") is a nonprofit legal organization that is dedicated to the advancement and protection of women's legal rights and to the rights of all people to be free from sex discrimination. Since 1972, the Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including employment, income security, education, and health and reproductive rights, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination. The Law Center has advocated specifically on issues affecting women's health care—from discrimination in health care to access to maternity and reproductive health care to protections under Medicaid, Medicare, and the Affordable Care Act—and has participated as *amicus curiae* in a range of cases before U.S. Courts of Appeals and the U.S. Supreme Court related to those issues.

The Lawyers' Committee and the Law Center have a particular interest in these cases as they implicate Medicaid waiver demonstration projects in the State of Arkansas and the Commonwealth of Kentucky that are counter to the purpose and objectives of the Medicaid Act, primarily the provision of health coverage to low-income people. In particular, the Lawyers' Committee and the Law Center oppose the Medicaid work requirements because of the disproportionate impact such requirements would have on women and communities of color—groups that rely on Medicaid for their health care and ability to continue to work.

ARGUMENT

This appeal involves the Department of Health and Human Services' ("HHS's") approval of invalid restrictions on access to health coverage in state Medicaid programs. Medicaid's express statutory purpose is to provide medical assistance to individuals who cannot afford it including many women and communities of color.[2] Plain and simple. Any Medicaid program[3] that diverges from this core purpose is a violation of statutory authority and cannot stand. Through Medicaid, millions of vulnerable low-income individuals benefit from access to much-needed health care.

In line with Medicaid's objectives, the Patient Protection and Affordable Care Act of 2010 ("ACA")[4] extends coverage to additional low-income nonelderly adults who otherwise would not qualify for Medicaid (the "expansion population").[5] Due

---

[2] Social Security Act of 1935 § 1901, 42 U.S.C. § 1396-1 (Medicaid was implemented "[f]or the purpose of enabling each State . . . to furnish . . . medical assistance . . . [to] individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . ."); *see Stewart v. Azar*, 366 F. Supp. 3d 125, 131 (D.D.C. 2019) ("*Stewart II*").

[3] As a jointly funded federal-state cooperative program, participating states must submit "plans for medical assistance" that meet certain minimum requirements. *See* 42 U.S.C. § 1396a (listing 83 separate requirements). State plans are approved by the Secretary of HHS. *Id*. § 1315. The Centers for Medicare and Medicaid Services ("CMS"), an agency within HHS, is responsible for monitoring the state-run programs to ensure compliance with federally-set standards. *See id.* § 1396a.

[4] *Id.* § 18001 *et seq*.

[5] *See id*. § 1396a(a)(10)(A)(i)(VIII) (extending Medicaid coverage effective January 1, 2014 to the "expansion population"). The ACA enabled states to extend Medicaid

to this expansion, the Commonwealth of Kentucky ("Kentucky") and State of Arkansas ("Arkansas") successfully added thousands of Medicaid beneficiaries to their programs.[6] Women and communities of color, in particular, have benefited from this coverage expansion. These groups disproportionately rely on Medicaid for critical health services for themselves and their families, which enables them to maintain their health and economic stability. Importantly, along with expanding Medicaid coverage, the ACA includes a number of provisions meant to address racial, ethnic, and sex-based discrimination and disparities in health care, which have already helped reduce discriminatory insurance practices and racial health disparities.[7]

---

assistance to "the entire nonelderly population with income below 133% of the poverty level." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012). States opting for Medicaid expansion receive additional federal funds to pay 100% of the states' Medicaid expansion costs through 2016 and 90% of those costs through 2020. 42 U.S.C. § 1396d(y).

[6] *See Stewart II*, 366 F. Supp. 3d at 131; *Gresham v. Azar*, 363 F. Supp. 3d 165, 171 (D.D.C. 2019).

[7] Simply by extending health insurance coverage to millions of uninsured Americans through a combination of insurance market reforms, insurance purchase mandates, and publicly funded subsidies for low-and middle-income purchasers, the ACA was expected to decrease racial disparity in access to health coverage. *See, e.g.*, 42 U.S.C. § 18031. In addition, the ACA includes a provision prohibiting discrimination on the basis of race, color, national origin, age, disability, and sex, which is the first broad federal prohibition against sex discrimination in health care. *Id.* § 18116. The ACA also requires all federally-supported health programs to collect and report data by race and ethnicity. *Id*. § 300(k)(k). Moreover, to address long-standing gaps in coverage of women's needs, the ACA: ended the practice of gender rating, which was rampant prior to its passage; disallowed a woman's gender

All of this progress, however, is in jeopardy. Both Kentucky and Arkansas have received approval from the Secretary of HHS to test certain "demonstration projects"[8] in their states known as Kentucky HEALTH and the Arkansas Works Amendments (AWA). While the Social Security Act authorizes the Secretary to approve demonstration projects in state Medicaid plans, the statute requires that such programs *must* promote the objectives of the Medicaid Act.[9] The Secretary's approvals of Kentucky HEALTH and AWA woefully fail in this regard. For example, in approving the Kentucky program, the Secretary fabricated "new" objectives of the Medicaid Act (e.g., financial independence, advancing health, fiscal sustainability).

This *amici* brief addresses the projects' community-engagement and work-related requirements (collectively, the "work requirements") and their impact on women and communities of color—event though these requirements are not the only harmful components of both programs. The work requirements are burdensome and self-defeating. For example, both state programs require beneficiaries to spend at

---

as a pre-existing condition; required small group and individual plans to cover maternity care; and required all new insurance plans and Medicaid expansion plans to cover a set of women's preventive services without cost-sharing. *See, e.g.*, 42 U.S.C. §§ 300gg, 300gg-3, 18022.

[8] *See id.* § 1315.

[9] *Id.* § 1315(a). Upon making the appropriate determination, the Secretary then has the power to waive compliance with the terms of § 1396a. *See id.* § 1315 (a)(1).

least 80 hours per month performing certain qualifying activities (e.g., employment, job-skills training, education, and community service), and also impose monthly reporting obligations. These requirements will result in devastating coverage losses. Indeed, when the AWA was in effect, over 18,000 beneficiaries in Arkansas lost coverage for noncompliance.[10] Likewise, if Kentucky HEALTH takes effect, it is anticipated that coverage losses equivalent to 95,000-297,500 beneficiaries will occur.[11]

Despite attempts in the district court to justify approval of these programs,[12] the Secretary has failed to rationally consider whether the programs would, in fact, further Medicaid's statutory purpose—to provide health coverage to those who cannot afford it.[13] The administrative records in both cases are riddled with

---

[10] *See* Ark. Dep't of Human Servs., *Arkansas Works Program* 8 (Dec. 2018), https://humanservices.arkansas.gov/images/uploads/011519_AWReport.pdf.

[11] As noted by the district court, estimates varied. In its waiver application, for example, Kentucky estimated that the project would cause more than 95,000 people to lose Medicaid coverage. *Stewart II*, 366 F. Supp. 3d at 140 (citing *Stewart v. Azar*, 313 F. Supp. 3d 237, 262 (D.D.C. 2018) ("*Stewart I*")). In contrast, *amici* Deans, Chairs and Scholars maintain that Kentucky's estimate was too conservative and that the real figure was likely between 175,000 and 297,500. *Stewart II*, 366 F. Supp. 3d at 140 (citations omitted). "Whatever the precise calculation, the number is undoubtedly substantial." *Id.*

[12] *See Stewart I*, 313 F. Supp. 3d 237; *Stewart II*, 366 F. Supp. 3d 125; *Gresham*, 363 F. Supp. 3d 165.

[13] *Stewart I*, 313 F. Supp. 3d at 265 (quoting *Beno v. Shalala*, 30 F.3d 1057, 1070 (9th Cir. 1994)); *see Stewart II*, 366 F. Supp. 3d at 131; *Gresham*, 363 F. Supp. 3d at 175.

deficiencies,[14] most notably the failure of the Secretary to consider the potential *loss of* coverage to the populations the Act was intended to cover, including women and people of color. Twice now, the district court has vacated the approval of Kentucky HEALTH and its work requirements, finding the Secretary's determination to be both "arbitrary and capricious" and contrary to the objectives of the Act.[15] The same finding was reached with respect to the Secretary's approval of AWA.[16] And, "[g]iven the seriousness of the [AWA] deficiencies," the court vacated the approval of AWA and ordered Arkansas to suspend the program.[17]

Accordingly, *amici* urge this Court to affirm the decisions below. The programs are punitive in nature and will create unnecessary hurdles to health care coverage for all Medicaid beneficiaries, especially women and communities of color. Complex documentation and administrative processes present a real risk that eligible individuals will lose coverage. The work requirements appear to be based on the false premise that Medicaid beneficiaries choose not to work and are taking advantage of the program's benefits. This is, in fact, a distortion of reality as studies

---

[14] *Stewart I*, 313 F. Supp. 3d at 265 ("Such review reveals that the Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid."); *Stewart II*, 366 F. Supp. 3d at 131; *Gresham*, 363 F. Supp. 3d at 177; *see* 42 U.S.C. § 1315 (setting forth the HHS Secretary's § 1115 waiver authority).
[15] *Stewart II*, 366 F. Supp. 3d at 131.
[16] *Gresham*, 363 F. Supp. 3d at 175.
[17] *Id.* at 169, 181-185

show that the majority of nonelderly adults enrolled in Medicaid are working[18] and that Medicaid has already assisted beneficiaries in finding or maintaining employment.[19]

In sum, these Medicaid work requirements fail to promote—and, indeed, will only serve to undermine—the objectives of Medicaid by decreasing access to "medical assistance" and "other services" that current beneficiaries depend on "for independence and self-care."[20] *Amici* submit this brief to inform the Court of the particular harm to women and communities of color likely to result from these state projects' work requirements.

I. WOMEN AND COMMUNITIES OF COLOR ARE MORE LIKELY TO RELY ON MEDICAID COVERAGE, BENEFITING THEIR HEALTH AND ECONOMIC STABILITY.

Due to various, and interacting, factors—including systemic discrimination and overrepresentation in the low-wage workforce—a disproportionately higher number of women and minorities are enrolled in Medicaid. Women, indeed, make

---

[18] Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Wor*k 2-3 (Feb. 15, 2017), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[19] *See id.*

[20] *See* 42 U.S.C. §§ 1315(a), 1396-1; *see also* Hannah Katch et al., Ctr. on Budget & Pol'y Priorities, *Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes* 3 (Aug. 13, 2018), https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce.

up the majority of adult Medicaid beneficiaries.[21] They also represent a significant segment of individuals who benefited from the ACA's expansion of Medicaid to cover nonelderly low-income individuals—a growth of 54% nationally.[22] Women, including women of color, especially rely on Medicaid coverage to obtain vital health services, including reproductive health care,[23] for themselves and their families.[24] Medicaid also plays a critically important role in advancing a woman's ability to work and maintain economic stability. Racial and ethnic minorities are also disproportionately represented among Medicaid's beneficiaries, making it a critical program for those communities. With Medicaid expansion, Kentucky and Arkansas made headway, for the first time, in narrowing the longstanding racial

---

[21] Nat'l Women's Law Ctr., *The Stealth Attack on Women's Health: Medicaid Work Requirements Would Reduce Access to Care for Women Without Increasing Employment* 2 (Jan. 2018), https://nwlc.org/wp-content/uploads/2017/04/Medicaid- Work-Requirements-1.pdf.

[22] Nat'l Women's Law Ctr., *Affordable Care Act Repeal and Changes to Medicaid Threaten the Health and Economic Security of 2.3 Million Working Women Who Recently Gained Coverage* 1 (Feb. 2017), https://www.nwlc.org/wp-content/uploads/2017/02/Working-Women-Health-Coverage-by-State.pdf.

[23] Although Medicaid covers a range of services women need, it is important to note that federal law restricts federal Medicaid coverage of abortion except if the pregnancy is the result of rape or incest, or if the woman's life is in danger. *See, e.g.,* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 202, 129 Stat. 2242, 2311 (2015).

[24] Nat'l Women's Law Ctr., *Underpaid & Overloaded: Women in Low-Wage Jobs* 3, 29-30 (2014), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/final_nwlc_lowwagereport2014.pdf.

disparities in insurance coverage—a first step in paving the path to the elimination of health inequities.[25]

A. Women Disproportionately Rely On Medicaid.

It is not surprising that the majority of adult Medicaid beneficiaries are women.[26] Women, including women of color, represent a larger share of the low-wage workforce, making them more likely to be eligible for Medicaid.[27] In 2017, they represented over half of the minimum wage workforce in 49 states and made up almost 70% of the occupations that pay less than $20,800 annually.[28] The issue is compounded for women of color, who make up nearly half of the low-wage

---

[25] *See* Susan L. Hayes et al., The Commonwealth Fund, *Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference?* 1 (Aug. 2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_aug_hayes_racial_ethnic_disparities_after_aca_ib.pdf ("Between 2013 and 2015, disparities with Whites narrowed for [B]lacks and Hispanics on three key access indicators: the percentage of uninsured working-age adults, the percentage who skipped care because of costs, and the percentage who lacked a usual care provider."); *see also* State Health Access Data Assistance Center (SHADAC), Found. for Healthy Ky., *Final Report: Study of the Impact of the ACA Implementation in Kentucky* 6 (Feb. 2017), https://www.healthy-ky.org/res/images/resources/Impact-of-the-ACA-in-KY_FINAL-Report.pdf; Commonwealth Fund, *Health Care Access & Affordability: Arkansas* (Dec. 2016).

[26] Kaiser Family Found., *Medicaid's Role for Women* 1 (March 2019), http://files.kff.org/attachment/Fact-Sheet-Medicaids-Role-for-Women.

[27] *Underpaid & Overloaded*, *supra* note 24, at 3.

[28] Kayla Patrick, Nat'l Women's Law Ctr., *Low Wage Workers Are Women: Three Truths and a Few Misconceptions* (Aug. 31, 2017), https://nwlc.org/blog/low-wage-workers-are-women-three-truths-and-a-few-misconceptions/.

workforce and are overrepresented in such jobs as child care workers, restaurant servers, and housekeepers.[29] Low-paying jobs have a particularly harsh impact on women of color as they are more likely to be single parents and sole supporters of their households.[30] Moreover, even in these low-wage jobs, women working full-time face a 13% wage gap, which is even greater for women of color.[31]

Other factors lead to a higher percentage of women Medicaid beneficiaries. Women have slightly higher rates of disability than men,[32] and the poverty rate for older women is much higher than it is for older men and, consequently, more elderly women rely on Medicaid.[33] Childbearing and motherhood also place unique constraints on a woman's economic stability, wages, labor-force participation, and occupational status.[34] And pregnant women with low incomes make up a significant group of women beneficiaries. In fact, by covering maternity-related services for

---

[29] Underpaid & Overloaded, supra note 24, at 3; Nat'l Women's Law Ctr., *Closing the Wage Gap Is Crucial for Women of Color and Their Families* 2 (Apr. 2015).
[30] *Id*.
[31] *Underpaid & Overloaded*, *supra* note 24, at 3; *see also* Nat'l Women's Law Ctr., *Equal Pay for Mothers Is Critical* 1-2 (June 2019) (providing statistics of wage gaps between mothers and fathers, which is even greater for women of color).
[32] *The Stealth Attack on Women's Health*, *supra* note 21, at 1.
[33] Amber Christ et al., Justice in Aging, *Older Women & Poverty* 3-4, 16 (Dec. 2018), https://www.justiceinaging.org/new-report-older-women-poverty/
[34] *See* Katherine Richard, Ctr. Glob. Pol'y Sol., *The Wealth Gap for Women of Color* 7 (Oct. 2014), http://www.globalpolicysolutions.org/wp-content/uploads/2014/10/Wealth-Gap-for-Women-of-Color.pdf.

pregnant beneficiaries, Medicaid ultimately pays for nearly half of all births in the United States.[35]

Women's reliance on Medicaid cannot be overstated. Following passage of the ACA, states saw a substantial increase in women Medicaid beneficiaries and a significant drop in uninsured non-elderly women.[36] In 2017, for example, about 6.7 million working women ages 18–64 had health insurance through Medicaid.[37] Approximately one-third of them—2.3 million—obtained such coverage between 2013 and 2015.[38] Indeed, after Medicaid expansion was implemented in Kentucky, the state witnessed a 220% increase in working women enrolled in Medicaid, including approximately 80,000 working women.[39] Arkansas likewise experienced a 136% increase during that period, with the addition of roughly 33,000 working women beneficiaries.[40] The expansion of Medicaid has undisputedly benefited women, including women of color, both below and above the poverty line by

---

[35] *See* MACPAC, *Access in Brief: Pregnant Women and Medicaid* 1 (Nov. 2018), https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf.

[36] Nationally, approximately 11% of nonelderly women were uninsured in 2017, a decline from a rate of 19% in 2013. Kaiser Family Found., *Women's Health Insurance Coverage* (Dec. 21, 2018), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/.

[37] *Affordable Care Act Repeal and Changes to Medicaid*, *supra* note 22.

[38] *Id.*

[39] *Id*. at 3.

[40] *Id*.

providing them access to much-needed health care services.[41] Accordingly, women represent a significant class of Medicaid beneficiaries at risk of losing health coverage in Kentucky and Arkansas because of the work requirements.

B. Communities Of Color Rely On Medicaid Services Because They Are More Likely To Live In Poverty And Face Barriers To Full-Time Employment.

Racial and ethnic minorities are disproportionately represented among nonelderly Medicaid beneficiaries and the magnitude of the program's importance in these populations is amplified in kind. In fact, one in five adults of color have coverage through Medicaid.[42] The program plays such a critical role in communities of color because they experience higher rates of poverty, unemployment and underemployment, and poor health outcomes.

Due to deep-rooted, systemic racial discrimination, minorities bear the brunt of poverty in America: the number of people of color who live in or near poverty

---

[41] Larisa Antonisse et al., Kaiser Family Found., *The Effect of Medicaid Expansion under the ACA: Findings form a Literature Review*, (Mar. 28, 2018), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/. Beneficiaries in the expansion program, in fact, are receiving more preventive care, visiting emergency rooms less, and skipping medications less. *Id.*

[42] Samantha Artiga et al., Kaiser Family Found., *What is at Stake for Health and Health Care Disparities under ACA Repeal* 1 (Mar. 20, 2017), https://www.kff.org/disparities-policy/issue-brief/what-is-at-stake-for-health-and-health-care-disparities-under-aca-repeal/.

does not correspond to their representation in the general population.[43] This national pattern is evident in the population of both Kentucky and Arkansas.[44] For example, in Kentucky, African Americans account for 7.7% of the state's total population, yet, of the Kentuckians living in poverty, 29.2% are African American.[45] Likewise, African Americans in Arkansas comprise 14.8% of the state's total population; however, of those in Arkansas living in poverty, 31.9 % are African American.[46]

Similarly, and undoubtedly related, communities of color face higher unemployment rates and are more likely to work non-standard jobs.[47] In addition to their prevalence in low-income households more broadly,[48] there are barriers to

---

[43] Poverty USA, *The Population of Poverty USA*, https://www.povertyusa.org/facts (last visited June 26, 2019). According to 2016 US Census Data, the poverty rates by race in descending order are as follows: Native Americans (27.6%); Blacks (26.2%); Hispanics (23.4%); and Whites (12.4%). *Id*.

[44] *See*, *e.g.*, Kaiser Family Found., *Poverty Rate by Race/Ethnicity* [hereinafter "Kaiser Poverty Rates"], https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 21, 2019).

[45] Poverty USA, *supra* note 43.

[46] *Id*.

[47] Jason Bailey, Ky. Ctr. For Econ. Research, *The State of Working Kentucky* 8 (Aug. 28, 2018), https://kypolicy.org/the-state-of-working-kentucky-2018/. In 2018, the state's unemployment rate for the White population was 4.8%, as compare to 8.6% for the African American population; the underemployment rates for the same populations were 12.6% and 8.5%, respectively. *Id*.

[48] The following, for example, are barriers to finding and obtaining employment common in low-income households regardless of race or ethnicity: lack of a cellphone or reliable transportation, childcare expenses, unstable housing, and insufficient education or training. *See, e.g.*, Jessica Gehr, CLASP, *Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers* (June

employment that specifically apply to minorities. Continued prejudice and discrimination in the labor market and workplace, for example, limit not only the number of opportunities, but also the quality and type of employment available to minorities.[49] In fact, Hispanics, African Americans, and American Indians/Alaska Natives are overrepresented in blue-collar occupations with incomes below the federal poverty level.[50] As a result, even though the majority of Hispanics, African Americans, and American Indians/Alaska Natives households have at least one full-time worker, they are more than twice as likely to be poor than White households.[51] Moreover, people of color are more likely to be part-time workers due to economic

---

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

[49] *See, e.g.,* Lincoln Quillian et al., *Hiring Discrimination Against Black Americans Hasn't Declined in 25 Years*, HARVARD BUS. REV. (Oct. 11, 2017) (finding that "[B]lacks remain substantially disadvantaged relative to equally qualified [W]hites"); Angela Hanks et al., Ctr. for Am. Progress, *Systematic Inequality: How America's Structural Racism Helped Create the Black-White Wealth Gap* (Feb. 2018) ("Persistent labor market discrimination and segregation also force [B]lacks into fewer and less advantageous employment opportunities than their [W]hite counterparts."). Moreover, racial minorities are not only disproportionately unemployed, but they are also more likely to work low-income, unstable jobs at wages less than their White counterparts. Amy Traub & Catherine Ruetschlin, DEMOS, *The Racial Wealth Gap: Why Policy Matters* (2016), http://www.demos.org/publication/racial-wealth-gap-why-policy-matters.

[50] Kaiser Family Found., *Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act* (Mar. 13, 2013), https://www.kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act/.

[51] *Id.*

reasons (i.e., would prefer full-time employment but unable to find it).[52] The minority employment rates also reflect the disparate impact of mass incarceration on communities of color. For example, African American men are incarcerated at more than five times the rate of White men, and the imprisonment rate for African American women is twice that of White women.[53] Physical imprisonment itself affects employment, and a criminal record diminishes future employment prospects.[54]

Finally, like employment discrimination, racial health disparities[55] are a significant strand in the tapestry of racial injustice of the United States—one that is inextricably intertwined with other historical and contemporary inequities as shaped

---

[52] CLASP, *The Struggles of Low-Wage Work* 1 (May 2018), https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf. For example, African American and Latino workers represent 27.9% of the working population but constitute 41.1% of all involuntary part-time workers. *Id*. Notably, part-time workers are three times less likely to have employer-provided health care or other benefits.

[53] NAACP, *Criminal Justice Fact Sheet*, https://www.naacp.org/criminal-justice-fact-sheet/ (last visited June 26, 2019); Derrick Darby & Richard E. Levy, *Postracial Remedies*, 50 U. MICH. J. L. REFORM 387, 401 (2016).

[54] *Id*. at 402.

[55] The term "health disparities" broadly refers to population level differences between demographic groups in measurements of health status, particular health outcomes, and the access to, utilization of, and quality of care. *See* Olivia Carter-Pokras & Claudia Baquet, *What is a "Health Disparity"?*, 117 PUB. HEALTH REP. 426, 427 (2002).

by institutional structures, policies, and societal norms.[56] Due to a myriad of causes, there are pervasive and long-standing differences in group health status and outcomes between minorities and Whites.[57] For example, in Kentucky, racial and ethnic minorities do worse than Whites on a range of health outcome measures, including rates of cancer, asthma, and diabetes.[58] Consequently, health coverage—Medicaid in particular—is vital for these segments of the population. Recent evidence demonstrates that the reduction in racial health disparities[59] is a promising achievement and highlights Medicaid's particular importance to Kentucky's communities of color.

---

[56] *See, e.g.,* Mary Crossley, *Black Health Matters: Disparities*, *Community Health, and Interest Convergence*, 22 MICH. J. RACE & L. 53, 53 (2016); Darby & Levy, *supra* note 53, at 398-407.

[57] David R. Williams & Ronald Wyatt, *Racial Bias in Health Care and Health: Challenges and Opportunities*, 314 JAMA 555, 555 (2015) ("In the United States, compared with [W]hite individuals, [B]lack individuals have earlier onset of multiple illnesses, greater severity and more rapid progression of diseases, higher levels of comorbidity and impairment through the life course, and increased mortality rates."); Crossley, *supra* note 56, at 60 ("Health inequality for Black people and other minorities is pervasive—it permeates measures of health care access, health status, and health outcomes.").

[58] Ky. Dep't of Pub. Health, Office of Health Equity, *2015 Kentucky Minority Health Status Report* (Nov. 23, 2015), http://chfs.ky.gov/NR/rdonlyres/0DBADAD5-90A8-4EB2-9D95-8EB751EBF8A6/0/2015KYMinorityHealthStatusReportFINAL21516latestayedits2.pdf.

[59] *See* Stacey McMorrow et al., *Uninsurance Disparities Have Narrowed for Black and Hispanic Adults Under the Affordable Care Act*, 34 HEALTH AFF. 1774, 1774 (2015) (finding that after one year of the ACA implementation, the uninsured rate for Blacks, Asian-Americans, and Hispanics dropped by more than 8%, while the rate for the White Non-Hispanic population dropped by just over 4%).

II. THE WORK REQUIREMENTS IMPOSED BY KENTUCKY HEALTH AND AWA THREATEN TO UNDO THE PROGRESS MADE IN EXPANDING COVERAGE TO THOSE WHO NEED IT, PARTICULARLY WOMEN AND COMMUNITIES OF COLOR.

By making it more difficult for individuals to retain coverage, the work requirements in Kentucky HEALTH and the AWA threaten to erode the progress made in expanding coverage through the ACA, thereby undermining the objective of the Medicaid program.

To maintain consistent Medicaid coverage under these state programs, beneficiaries would be required to either document their exemption status, obtain and retain employment, or fulfill community engagement activities and report completed activity hours monthly. Potential barriers to compliance with the requirements—including limited or no vehicular and internet access, serious health limitations, and fluctuating work hours—could lead to a loss of coverage. As has already been found in one study concerning the impact of AWA on beneficiaries, the imposition of work requirements "substantially exacerbated administrative hurdles to maintaining coverage" as the program was plagued with confusion and a lack of awareness by its participants.[60]

Work requirements like those imposed under Kentucky HEALTH and AWA will push, or continue to push, beneficiaries out of the program, causing a significant

[60] Benjamin D. Sommers et al., N. ENGL. J. MED., *Medicaid Work Requirements - Results From the First Year in Arkansas* 8 (2019).

decrease in health care coverage. Kentucky estimates, for example, "that 15 percent of adult beneficiaries—about 95,000 individuals—will lose coverage due to work requirements and other provisions of its waiver."[61] Arkansas, in the time that AWA was in effect, experienced a loss of 18,000 beneficiaries. The program poses a particular risk to women and to racial and ethnic minorities who are more likely to encounter obstacles to satisfying the work requirements[62] and less likely to be exempt than their White counterparts.[63]

A. Women Will Be Particularly Harmed By The Work Requirements.

Because women make up 57% of the nonelderly Medicaid beneficiaries in Arkansas and Kentucky, they will plainly be disproportionately and negatively impacted by the work requirements.

---

[61] *Id*.

[62] As discussed further *infra*, minority beneficiaries subject to the work requirements face particularly high barriers to finding and retaining employment.

[63] Certain beneficiaries may qualify for exemptions from the work requirements, such as children under the age of 19, adults 65 and over, beneficiaries who qualify for Medicaid because they receive disability benefits, pregnant women, full-time students, people who are "medically frail" and primary caregivers of a dependent minor or a disabled adult. Research indicates that the exemptions disproportionately help White people. *See, e.g.*, Anuj Gangopadhayaya & Genevieve M. Kenney, Urban Institute, *Who Could Be Affected by Kentucky's Medicaid Work Requirements, and What Do We Know about Them?* 1 (February 2018), https://www.urban.org/sites/default/files/publication/96576/2018.02.15_ky_medicaid_numbers_finalized_0.pdf (finding that the exemptions would disproportionately help White people).

Work requirements will disproportionately affect women, including women of color, because of factors that are more common among women and make it more difficult to meet a work requirement.[64] Such factors include historical barriers to employment, overrepresentation in the low-wage workforce, caregiving responsibilities and a lack of childcare, and lack of transportation. Medicaid work requirements often limit the activities that count as work and often discount or ignore women's caregiving responsibilities. Kentucky HEALTH and AWA's *80-hour* work requirements, in particular, may be unattainable, even for Medicaid beneficiaries with regular employment, if they are balancing other family obligations or are engaged in part-time work with irregular schedules. And for women who may qualify for caregiving exemptions under the programs, they still face obstacles in navigating the exemption process and complying with reporting requirements.[65] Confusing paperwork, lack of internet access, and website issues are just some of the challenges reported.[66] Women who are balancing part-time work and care-giving responsibilities will continually have to address their eligibility status, increasing the chances of gaps in coverage and inability to access the care they need.

---

[64] *The Stealth Attack on Women's Health*, *supra* note 21, at 2.
[65] *See* Natalie Kean, Justice in Aging, *Medicaid Work Requirement: The Impact on Family Caregivers and Older Adults* 8-9 (Nov. 2018).
[66] *Id*.

The foregoing work requirement factors and demands stand to threaten the economic stability Medicaid coverage contributes to for many women. Medicaid has served to help women find and maintain employment, particularly when they are receiving preventive care or treatment for a health problem that poses a barrier to employment. To erect any additional obstacles to women's continued access to healthcare is directly at odds with the purpose of Medicaid, will result in a loss of coverage, will threaten women's health, and is unwarranted in light of studies showing that most Medicaid beneficiaries are actually satisfying work-related requirements in one way or another.[67]

B. Implementation Of Work Requirements Will Disproportionately Harm Communities Of Color In Kentucky And Arkansas.

Communities of color will be significantly and disproportionately impacted by the Medicaid work requirements in Kentucky HEALTH and the AWA. The racial disparities connected to the work requirements result from the disproportionate representation of minorities in the general Medicaid population, work requirement exemptions that favor White Medicaid beneficiaries, and discretionary features of the plan's implementation process that invite further inequity. The potential for massive coverage loss, particularly among minorities,

[67] Katch et al., *supra* note 20; Sommers et al., *supra* note 60.

conflicts directly with Medicaid's purpose and will further exacerbate racial health disparities.[68]

Because communities of color are overrepresented in the Medicaid populations of both Kentucky and Arkansas, the loss of coverage will, in all likelihood, include a disproportionate number of racial and ethnic minorities. This is especially likely given that communities of color face higher rates of poverty, unemployment, and underemployment. With Medicaid expansion under the ACA, Kentucky and Arkansas made headway, for the first time, in narrowing the longstanding racial disparities in insurance coverage.[69]

Kentucky experienced one of the largest declines in rates of uninsured persons after implementation of the ACA.[70] This reflects rate reductions across races: from 17.3% to 5.5% for African Americans; 12.6% to 5.3% for Caucasians; 15.5% to 8.2% for the multiracial population; 28.7% to 24.2% for Hispanics; and 16.9% to 12.5% for Asians.[71] In Arkansas, the rates of uninsured nonelderly adults decreased from 24% in 2013 to 14% in 2015.[72] By race, during that same time period, the

---

[68] Katch et al., *supra* note 20.
[69] *See, e.g.,* Found. for Healthy Ky., *Final Report*, *supra* note 25, at 4; Kaiser Family Found., *Medicaid in Arkansas* 1 (Nov. 2018), http://files.kff.org/attachment/fact-sheet-medicaid-state-AR.
[70] Found. for Healthy Ky., *Final Report*, *supra* note 25, at 4.
[71] *Id*. at 6.
[72] Commonwealth Fund, *Health Care Access & Affordability: Arkansas* (Dec. 2016).

uninsured rates fell from: 21% to 11% among Caucasians; 28% to 11% among African Americans; 51% to 38% among Hispanics; and 24% to 15% among other races.[73]

Nevertheless, racial insurance gaps remain, and people of color are still at higher risk of being uninsured than Whites.[74] In fact, while racial and ethnic minorities comprise 42% of the overall nonelderly population in the United States, they account for over half of the total nonelderly uninsured population.[75] The inevitable result of the states' Medicaid work requirements is an enormous loss of coverage that will undo the progress Kentucky and Arkansas have made in reducing their uninsured, especially within communities of color.[76]

---

[73] *Id.*

[74] Rachel Garfield et al., Kaiser Family Found., *The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act* (Jan. 25, 2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-who-remains-uninsured-after-the-aca-and-why-do-they/.

[75] *Id.* Nationally, Hispanics (18.9%) and African Americans (11.1%) still have significantly higher nonelderly uninsured rates than Whites (7.3%). *Id.*

[76] Samantha Artiga et al., Kaiser Family Found., *Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA, 2013-2017* (Feb. 13, 2019), https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/.

Furthermore, the definition of "working"[77] under Kentucky HEALTH and the AWA completely ignores certain race-specific discrepancies among the Medicaid enrollee population and the employment challenges that disproportionately affect people of color, such as higher rates of poverty,[78] unemployment and barriers to employment or full time employment,[79] *see supra* § IB, and chronic illness.[80] They also fail to consider general factors that affect compliance with the work requirement such as the realities of low-income jobs, states' depressed economies, and state unemployment rates higher than the national average. Another such obstacle to securing "work," as defined in the plan, is the fact that some of the states' largest industries are food services and construction (Kentucky) and agriculture and

---

[77] The exemptions under the work requirement programs in Kentucky and Arkansas may, in fact, disproportionately favor White Medicaid beneficiaries. *See* Gangopadhayaya & Kenney, *supra* note 63. One study examining the composition of Kentucky's Medicaid population found that, of the beneficiaries likely to be exempt from the work requirement, 78% were White—compared to 15% African American and 2% Hispanic. *Id*. In Arkansas, the beneficiaries likely to be exempt were 69% White, 22% African American, and 5% Hispanic. Anuj Gangopadhayaya et al., Urban Institute, *Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know about Them?* 13 (May 2018), https://www.urban.org/research/publication/medicaid-work-requirements-arkansas/view/full_report.

[78] Kaiser Poverty Rates, *supra* note 44.

[79] Bureau of Labor Statistics, *Preliminary 2018 Data on Employment Status by State and Demographic Group*, https://www.bls.gov/lau/ptable14full2018.pdf. The overall unemployment rate in 2018 was 4.4%, however the unemployment rate for Black residents was 6.5% (7.1% for men and 6% for women). *Id*. For those Hispanic or Latino residents, unemployment was 5.5%. *Id*.

[80] *See generally* Crossley, *supra* note 56.

manufacturing (Arkansas), which tend to involve lower paying jobs with unstable hours and no benefits.[81]

The inequities related to the work requirements will be magnified in its function. Discretionary features of the plan's implementation process are rife with the potential for increasing racial health disparities; in fact, the limited implementation steps Kentucky already has taken provide one such example. The plan authorizes the state to exempt entire counties from the work requirements if the county has high unemployment rates, limited economy, lack of educational opportunities, or inadequate public transportation.[82] When Kentucky HEALTH was scheduled to become effective in April 1, 2019, the state had determined that eight southeastern counties qualified for exemption; each county has a population that is 90% White. Accordingly, the entire population of Medicaid beneficiaries in these counties are deemed exempt from the work requirements. In contrast, roll-out of the work requirements was set to begin in a region including the county with the highest concentration of Black residents.[83] While the county exemptions are aimed at

---

[81] *See, e.g.*, Katch et al., *supra* note 20.
[82] Kentucky HEALTH Waiver Application § VII(48)(j), p. 73.
[83] Ed Kilgore, *3 States Are Pushing Medicaid Reforms That Discriminate Against Black People*, INTELLIGENCER (May 14, 2018), http://nymag.com/intelligencer/2018/05/discriminatory-medicaid-work-requirements-spread-to-3-states.html; Alice Ollstein, *Trump Admin Poised To Give Rural Whites A Carve-Out On Medicaid Work Rules*, TMP (May 14, 2018), https://talkingpointsmemo.com/dc/trump-admin-poised-to-give-rural-whites-a-

addressing a genuine problem—very real roadblocks to employment in certain areas—the result is a disproportionate application of the work requirements along race lines.

As a final note, work requirements employed in other social service programs have revealed the danger of implementation biases and have resulted in demonstrable prejudice.[84] For example, the Urban Institute found that African Americans and Hispanic TANF recipients were more likely to be sanctioned for noncompliance with program rules than white recipients with similar work histories and that caseworker bias can affect sanctioning outcomes.[85] Because the Medicaid work requirements allow for similar discretion in the application of sanctions for non-compliance, Kentucky HEALTH and the AWA are vulnerable to the same biases.

---

carve-out-on-medicaid-work-rules; *see also* Lisa Gillespie, *Northern Ky. Expected To Be First Area Affected By New Medicaid Work/Training Requirement*, WKMS (Apr. 5, 2018), https://www.wkms.org/post/northern-ky-expected-be-first-area-affected-new-medicaid-worktraining-requirement#stream/0.

[84] *See, e.g.*, Ariel Kalil et al., *Sanctions and Material Hardship under TANF*, SOC. SERV. REV., vol. 76, no. 4, at 655 (2002) ("We find that limited education and being African American predict sanctioning when we control for a wide range of other personal and demographic characteristics."); Robin Koralek, Urban Institute, *South Carolina Family Independence Program Process Evaluation* 12 (2000); Karen Westra & John Routley, Ariz. Dep't of Econ. Sec., *Arizona Cash Assistance Exit Study: First Quarter 1998 Cohort* 16 (January 2000).

[85] Koralek, *supra* note 84, at 12.

Such an expected loss of health coverage due to state programs like Kentucky HEALTH and AWA is antithetical to Medicaid's overarching purpose and, consequently, the programs must be suspended.

CONCLUSION

For the reasons set forth herein, and in the Appellees' brief, the judgments below should be affirmed.

Respectfully submitted,

/s/ Judith R. Nemsick
Judith R. Nemsick
Caitlin Stachon
HOLLAND & KNIGHT LLP
31 West 52nd Street, 12th Floor
New York, New York 10019
Tel.: (212) 513-3200
Fax: (212) 385-9010
judy.nemsick@hklaw.COM
caitlin.stachon@hklaw.COM

Christopher Bellows
HOLLAND & KNIGHT LLP
701 Brickell Avenue, Suite 3300
Miami, Florida 33131
Tel.: (305) 374-8500
Fax: (305) 789-7799
christopher.bellows@hklaw.COM

Counsel for Amici Curiae

Dated: June 27, 2019

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because the brief contains 6,337 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). This brief complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5) and 32(a)(6), respectively, because this brief has been prepared in a proportionately spaced typeface using Microsoft Word 2010 in Times New Roman 14-point font.

/s/ Judith R. Nemsick
Judith R. Nemsick

CERTIFICATE OF SERVICE

I hereby certify that on June 27, 2019, I electronically filed the foregoing notice with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. All participants in this case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Judith R. Nemsick
Judith R. Nemsick