UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 1:18-cv-152 (JEB)
	)	
	)	
ALEX M. AZAR II, *et al.*,	)	
	)	
Defendants.	)	

COMMONWEALTH OF KENTUCKY'S MOTION FOR SUMMARY JUDGMENT & RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

For the reasons explained in the attached memorandum, the Court should grant the Commonwealth of Kentucky's motion for summary judgment and deny Plaintiffs' motion for summary judgment. *See* Fed. R. Civ. P. 56.

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CERTIFICATE OF SERVICE

I certify that on February 4, 2019 I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice and copies to all counsel of record registered with the Court's ECF system.

/s/ M. Stephen Pitt
Counsel for the Commonwealth of Kentucky

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COMMONWEALTH OF KENTUCKY'S MEMORANDUM IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT & RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This matter is nothing more than an obvious attempt on the part of the Plaintiffs to have the Court play the role of a super-legislative policy maker. Congress has expressly delegated authority to the Secretary to waive certain requirements of the Medicaid Act so that the states, as the laboratories of democracy, may determine what works best for them. Although the Plaintiffs may not like the conclusion that the Secretary has arrived at, this does not mean that the decision to re-approve Kentucky HEALTH was without a rational basis or otherwise not statutorily authorized.

FACTUAL BACKGROUND

On August 24, 2016, Governor Matthew G. Bevin submitted Kentucky's Section 1115 waiver application to the Secretary of the Department of Health and Human Services. (AR at 5432.) Governor Bevin explained that circumstances unique to Kentucky drove the need for and the proposed terms of Kentucky HEALTH. (AR at 5433.) From the outset, Governor Bevin made clear that the approval of Kentucky HEALTH, a program that mostly affects Kentucky's Medicaid expansion population, was the vehicle for the Commonwealth's continued participation in expanded Medicaid. (*See* AR at 5432.)

On January 12, 2018, the Secretary approved Kentucky HEALTH. (AR at 1-10.) On the same day, Governor Bevin issued an executive order about Kentucky HEALTH, explaining:

> [T]he Commonwealth will not be able to afford to continue to operate its Medicaid expansion program as currently designed in the event any one or more of the components of Kentucky's Section 1115 Waiver and the accompanying Special Terms and Conditions are prevented by judicial action from being implemented within the demonstration period set forth in the Special Terms and Conditions.

(ECF 25-1 at 4.) Governor Bevin thus ordered that if any aspect of Kentucky HEALTH is ultimately enjoined by a court, the responsible state officials are "directed to take the necessary

actions to terminate Kentucky's Medicaid expansion program." (*Id.*) In other words, if this case ultimately is successful in whole or in part, expanded Medicaid in Kentucky will be no more.

Nevertheless, Plaintiffs filed the instant litigation challenging Kentucky HEALTH. Kentucky intervened in the litigation. (ECF 1; Minute Order 3/30/18.) After merits briefing, the Court vacated the Secretary's approval of Kentucky HEALTH and remanded the matter upon concluding 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 v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018).

On November 20, 2018, the Secretary again approved Kentucky HEALTH under Section 1115. (AR at 06718.) The Secretary reasoned that, "an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a matter that prioritizes meeting those needs." (AR at 06719) To that end, the Secretary approved, among other things, a community-engagement program, which will get enrollees into their communities in a variety of ways; a premium requirement, which will encourage personal responsibility and mirror commercial coverage; and *My Rewards* accounts for enrollees, which will incentivize healthy behaviors to unlock enhanced benefits. (AR at 06721-06725.)

The Secretary also squarely addressed the issue that precipitated the Court's remand. The Secretary acknowledged that providing medical assistance is an "important objective of the Medicaid program," but explained that "[t]here is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence." (AR at 06719.) The Secretary underscored that Kentucky HEALTH advances the provision of medical assistance in several ways—for

example, it provides coverage beyond what Kentucky is required to provide (*i.e.*, dental benefits, vision services, and fitness-related services) and it "will enable the Commonwealth to continue to offer Medicaid to the ACA expansion population." (AR at 06726.)

The Secretary also addressed the concerns that Kentucky HEALTH may result in loss of coverage. *Stewart*, 313 F. Supp. 3d at 263. The Secretary determined that "it is not accurate to assume, as some commenters did, that this [figure] reflects that 95,000 individuals will completely lose coverage and not regain it." (AR at 06731.) The Secretary gave several reasons for this conclusion, among them being that the projection included individuals who would graduate up to commercial coverage, and that the projection was made before "additional beneficiary guardrails" were included in Kentucky HEALTH. (AR at 06731.) The Secretary also reasoned that any decrease in coverage is "likely dwarfed by the 454,000 newly eligible adults who stand to lose coverage if Kentucky elects to terminate the non-mandatory ACA expansion." (AR at 06732.)

On January 14, 2019, Plaintiffs filed an amended complaint to challenge the Secretary's revised approval of Kentucky HEALTH. (ECF 88.) On the same day, Plaintiffs filed a summary-judgment motion that, with some exceptions, generally tracks the argument they made the first time around. (ECF 91-1.) For the reasons that follow, the Court should deny Plaintiffs' motion for summary judgment and grant summary judgment to the defendants.

STANDARD OF REVIEW

Section 1115 of the Social Security Act enables the Secretary to "waive compliance with any of the requirements of section . . . 1396a" for "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a)(1). Section 1115 allows the Secretary to "test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962).

Plaintiffs claim that Section 1115 only gives the Secretary "narrow" authority (ECF 88 ¶ 2), but the Court has already acknowledged that the Secretary has "considerable discretion" under Section 1115. *See Stewart*, 313 F. Supp. 3d at 256 (citation omitted). Section 1115, another court has similarly held, grants "broad power to the Secretary to authorize projects which do not fit within the normal [Medicaid] guidelines." *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 493 (N.D. Cal. 1972); *Crane v. Mathews*, 417 F. Supp. 532, 539 (N.D. Ga. 1976) (similar). Judge Friendly correctly labeled the Secretary's Section 1115 waiver authority as "extensive." *Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973).

For present purposes, the key component of Section 1115 is that it vests the Secretary, and no one else, with the "judgment" to determine whether a project is "likely to assist in promoting the objectives" of Medicaid. Section 1115, the Second Circuit has held, "speak[s] in terms of an otherwise unfettered 'judgment'" for the Secretary and "does not require that, before the Secretary approves an experiment, every i must be dotted and t must be crossed." *Id.* at 1107. More to the point, "[t]he requirements of § 1115 do not require certainty much less prescience, on the Secretary's part as to the results." *Richardson*, 348 F. Supp. at 497. By its terms, Section 1115 only requires that, in the Secretary's judgment, it be likely—not certain—that a proposed project assists in promoting—not that the project itself promotes—the objectives of Medicaid.

In reviewing the Secretary's judgment that a project likely assists in promoting the objectives of Medicaid, the question is, at most,[1] "whether the Secretary *had a rational basis*" for approving a Section 1115 waiver. *Aguayo*, 473 F.2d at 1105 (emphasis added); *see also C.K. v.*

[1] Because the statute turns on the Secretary's judgment, the Commonwealth agrees with the federal defendants that the Secretary's decision about whether Kentucky HEALTH is "likely to assist in promoting the objectives" of Medicaid is judicially unreviewable. *See Drake v. FAA*, 291 F.3d 59, 72 (D.C. Cir. 2002).

N.J. Dep't of Health & Human Servs., 92 F.3d 171, 183 (3d Cir. 1996) (asking whether the "record discloses that the Secretary rationally could have determined that . . . [the] program was 'likely to assist in promoting the objectives'" of Medicaid); *Cooper Hosp./Univ. Med. Center v. Burwell*, 179 F. Supp. 3d 31, 51 (D.D.C. 2016) (similar). In applying this deferential standard, the Court is not to be a social scientist, scientific critic, or policymaker, nor is it to "comment upon the wisdom" of the waiver. *See C.K.*, 92 F.3d at 181; *Richardson*, 348 F. Supp. at 497-98. More generally, "[t]he court is not empowered to substitute its judgment for that of the [Secretary]." *Aguayo*, 473 F.2d at 1107 (quoting *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971)).

Under this standard of review, the Court should uphold the Secretary's judgment that Kentucky HEALTH as a whole likely will assist in promoting the "objectives" of Medicaid. The threshold question in this inquiry is "What are the objectives of Medicaid?" Unhelpfully, neither Section 1115 nor any other provision of the Medicaid Act neatly lists those objectives. Complicating matters further, Kentucky HEALTH primarily affects the able-bodied members of the Medicaid expansion population, which is different in many respects from the core populations historically served by Medicaid. It stands to reason that the "objectives" of Medicaid for this able-bodied population are different in certain respects from the traditional Medicaid population. *See NFIB v. Sebelius*, 567 U.S. 516, 583 (2012) ("The Medicaid expansion . . . accomplishes a shift in kind, not merely degree."). Because of these two layers of ambiguity, the Secretary receives *Chevron* deference in defining the "objectives" of Medicaid for purposes of Section 1115. *See Pharm. Res. & Mfrs. Am. v. Thompson*, 362 F.3d 817, 821-22 (D.C. Cir. 2004). In fact, this Court has already assumed that this is true. *See Stewart*, 313 F. Supp. 3d at 268 ("To the extent the Secretary means that he should receive deference in interpreting the 'objectives' of Medicaid under Section 1115 more generally, the Court assumes he is correct.").

ARGUMENT[2]

I. Approving Kentucky HEALTH was well within the Secretary's judgment as Kentucky HEALTH furthers the objectives of the Medicaid Act.

(A) Promoting health and wellness as an objective of Medicaid. The objectives of Medicaid are not simply paying for Medicaid services. As the Secretary concluded "an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries . . . ." (AR at 06719.) This is not only a permissible construction of Section 1115, but the correct one. Nor is it a novel reading of the Medicaid Act. The previous administration, like the current one, concluded that this was the correct reading of the statute. *See* CMS, *Frequently Asked Questions on Exchanges, Market Reform, and Medicaid*, at 15 (Dec. 10, 2012) (encouraging states to develop initiatives "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health care outcomes"), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf (last visited Feb. 4, 2019). This understanding of promoting health and wellness as an objective of Medicaid goes back decades. As the federal defendants observed in the *Gresham* matter, President Lyndon Johnson, who signed the Medicaid Act, espoused this belief in his 1964 State of the Union address. *See Gresham v. Azar*, ECF 37-1 at 17 ("Our aim is not only to relieve the symptoms of poverty, but to cure it and, above all, to prevent it.").

This understanding of promoting health and wellness as an objective of Medicaid is grounded in the Medicaid Act's provisions. In approving Kentucky HEALTH, the Secretary reasoned that 42 U.S.C. § 1396-1—the Medicaid appropriations provision—"makes clear that an

[2] Although the Court has already rejected Kentucky's standing arguments, the Commonwealth continues to assert them. (*See* ECF 50-1 at 3-9; ECF 63 at 2-10.)

important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations." (AR at 06719.) (The Commonwealth does not concede that the Medicaid appropriations provision lists all the purposes of Medicaid or that this statute fully describes the purposes of Medicaid vis-à-vis the expanded population.) The Medicaid Act, in turn, defines "medical assistance" as not only paying for the costs of medical care, but also the medical care itself. 42 U.S.C. § 1396d(a) ("The term 'medical assistance' means payment of part or all of the cost of the following care and *services or the care and services themselves*, or both." (emphasis added)). The Affordable Care Act amended the term "medical assistance" in this respect. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2304, 124 Stat. 119, 296-97 (2010). Some pre-ACA legislative history suggests this was a response to court opinions that had narrowly interpreted "the term to refer only to payment" for medical care, which created problems in interpreting the Medicaid Act. *See* H.R. Rep. 111-299, at 650 (2009). Consequently, when Congress expanded Medicaid, it also reaffirmed that "medical assistance" encompasses both paying for care as well as the care itself.

This is an important point. This broadened definition of "medical assistance" confirms that the Medicaid program is not all about ensuring that covered populations do not have to pay for medical care. Medicaid is equally concerned with the medical care itself. Because Medicaid is directed to medical care, as opposed to just making sure that care is paid for, it necessarily follows that Medicaid is concerned with promoting health and wellness. To be concerned about medical care, as the Medicaid Act is, is to be concerned about health and wellness. The Secretary adopted this very line of thinking in approving Kentucky HEALTH: "[T]here is little intrinsic value in paying for services if those services are not advancing the wellness of the individual receiving

them, or otherwise helping the individual attain independence." (AR at 06719.) At the very least, this is a permissible construction of the Medicaid Act.

Medicaid's objective of promoting health and wellness also can be seen in the requirement that "medical assistance" be provided with "reasonable promptness." 42 U.S.C. § 1396a(8) ("[A]ssistance shall be furnished with reasonable promptness to all eligible individuals"). Making sure that medical care is timely received is undeniably linked to health and wellness. Generally speaking, the longer one goes without needed medical care, the worse one's health gets. By requiring that medical assistance be provided with "reasonable promptness," the Medicaid Act clearly aims to promote health and wellness. In fact, according to legislative history, the Medicaid Act's focus on "reasonabl[y] prompt[]" medical assistance was one of the main reasons that the Affordable Care Act broadened the definition of "medical assistance" to include medical care. *See* H.R. Rep. 111-299, at 650 ("If the term ["medical assistance"] meant only payments, the statutory requirement that medical assistance be furnished with reasonable promptness 'to all eligible individuals' in a system in which virtually no beneficiaries receive direct payments from the state or federal governments would be nearly incomprehensible.").

It was rational for the Secretary to conclude that, in his judgment, Kentucky HEALTH likely would assist in promoting health and wellness. Several aspects of the project work in tandem toward this end. Starting with the community-engagement requirement, which requires able-bodied enrollees to spend 80 hours in their communities each month, the Secretary reasoned that it is "designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness." (AR at 06724.) The *My Rewards Account* approaches improving health and wellness from a different angle. Plaintiffs' brief barely mentions the *My Rewards Account*, but it is a central feature of Kentucky HEALTH

that rewards healthy behavior, like receiving preventative care, by unlocking virtual funds to pay for optional Medicaid benefits. (AR at 06721, 06724.) By focusing on preventative care, the *My Rewards Account* responds to a pressing problem among Medicaid recipients in Kentucky: "During the first year of Kentucky's Medicaid expansion, fewer than 10 percent of beneficiaries in the ACA expansion population received an annual wellness or physical exam." (AR at 06724.) The *My Rewards* account, the Secretary concluded, offers "incentives for healthy behaviors [that] are intended to increase uptake of preventative services." (*Id.*)

The Secretary also found that, in his judgment, the payment of modest premiums is consistent with increasing health and wellness. As evidence, he noted: "[I]nterim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventative care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not." (AR at 06734-06735.) The Secretary made similar health-and-wellness findings for Kentucky HEALTH's waiver of retroactive eligibility (AR at 06736) and the redetermination and reporting requirements (AR at 06736). In sum, the Secretary rationally determined that the various components of Kentucky HEALTH worked together to promote health and wellness as an objective of Medicaid.

(B) Medicaid sustainability as an objective of Medicaid. In addition to promoting health and wellness, the Secretary determined that "furnish[ing] medical assistance in a manner that improves the sustainability of the safety net" is an objective of Medicaid. (AR 06726, 06719-06720.) This objective of Medicaid has been recognized by the Supreme Court, the D.C. Circuit, and other district courts, and it is reflected in various provisions of the Medicaid Act. It also is intrinsic in the notion of a cooperative federal-state program like Medicaid.

The Medicaid appropriations provision states that one of its "purposes" is to provide medical assistance to specified populations "as far as practicable *under the conditions in such State.*" 42 U.S.C. § 1396-1 (emphasis added). Congress expressly provided that the "conditions in such State" and practicability inform how each State is to administer its Medicaid program. This statutory language shows that an objective of Medicaid is that it remain sustainable. Medical assistance, Congress affirmed, should only go "as far as practicable under the conditions in such State." *Id.*

Case law confirms that the sustainability of Medicaid is an objective of Medicaid. In *Thompson*, *supra*, for example, the D.C. Circuit relied on the Supreme Court's decision in *PhRMA v. Walsh*, 538 U.S. 644 (2003), to accept as reasonable the Secretary's conclusion that measures aimed at conserving scarce state Medicaid resources "further[s] the goals and objectives of the Medicaid program." *Thompson*, 362 F.3d at 825. At issue in *Thompson* was a state measure that made getting certain drugs more difficult for Medicaid recipients by requiring prior authorization, which was meant to encourage drug companies to give rebates for those not receiving Medicaid. This, the Secretary reasoned, helped to keep non-Medicaid beneficiaries from becoming Medicaid eligible. *Id.* at 820-21. The Secretary argued that this program was consistent with Medicaid's "goals and objectives" because, "[i]ncreased Medicaid enrollments and expenditures for newly qualified Medicaid recipients *will strain already scarce Medicaid resources in a time of State budgetary shortfalls.*" *Id.* at 825 (emphasis added). The D.C. Circuit found this interpretation to be reasonable:

> The Secretary's conclusion that a prior authorization program that serves Medicaid goals in this way can be consistent with Medicaid recipients' best interests, as required by section 1396a(a)(19), is reasonable on its face. If the prior authorization program prevents borderline populations in Non-Medicaid programs from being displaced into a state's Medicaid program, *more resources will be available for existing Medicaid beneficiaries.*

Id. (emphasis added). In reaching this conclusion, *Thompson* relied heavily on the plurality's analogous conclusion in *Walsh*. 538 U.S. at 663 ("[T]here is the possibility that, by enabling some borderline aged and infirm persons better access to prescription drugs earlier, Medicaid expenses will be reduced. If members of this borderline group are not able to purchase necessary prescription medicine, their conditions may worsen, causing further financial hardship and thus making it more likely that they will end up in the Medicaid program and require more expensive treatment."). Furthermore, *Thompson* also noted that Justice O'Connor's separate opinion in Walsh "suggested that this rationale, although 'not self-evident,' would suffice if supported by facts in the record." *Thompson*, 362 F.3d at 825. *Thompson* and *Walsh* thus stand for the proposition that a valid objective of Medicaid is ensuring Medicaid's sustainability by conserving scarce state resources.

At least two district courts have reached an identical conclusion in upholding Section 1115 demonstration projects. For example, in *Crane*, the district court concluded: "The public purse, both that of the state and even of the United States, is not absolutely unlimited. Accordingly, public officials must make some effort to provide the greatest good possible at the least possible costs. That appears to be the underlying motive behind this project, and it is one to be commended, and not one to be criticized." *See Crane*, 417 F. Supp. at 540. Similarly, in *Richardson*, the district court upheld a Section 1115 waiver, noting that "[t]he stated purposes of the . . . experiment might be expressed as an attempt to see how imposition of some cost-sharing will decrease utilization of the program benefits, and, consequently, costs." *Richardson*, 348 F. Supp. at 496.

It was rational for the Secretary to conclude that, in his judgment, Kentucky HEALTH is likely to assist in making Medicaid more sustainable in the Commonwealth. The Secretary relied on four broad sustainability rationales. First, he noted that, by improving health and wellness, Kentucky HEALTH "may reduce the volume of services consumed, as healthier, more engaged

beneficiaries tend to consume fewer medical services and are generally less costly to cover." (AR at 06719.) Second, the Secretary found that "measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance from the state." (*Id.*) On both points, the Secretary reasoned "[s]uch measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover" and "may also preserve states' ability to continue to provide the optional services and coverage they already have in place." (AR at 06719-06720.) Both of these sustainability rationales track the Medicaid objective endorsed in *Thompson* and *Walsh*. *See, e.g.*, *Thompson*, 362 F.3d at 825.

Third, the Secretary noted that Kentucky has chosen, in its discretion, to use the *My Rewards* account component of Kentucky HEALTH to provide optional benefits to enrollees, like dental benefits, vision coverage, and over-the-counter prescriptions. (AR at 06721.) The Commonwealth, the Secretary further observed, was even utilizing its Section 1115 waiver to provide benefits that are not typically associated with Medicaid, such as fitness-related benefits and an SUD program to address the opioid crisis in Kentucky. (AR at 06726.) In light of these optional and non-Medicaid services, the Secretary reasoned that sustainability was not just an end in itself, but something that allowed enrollees access to enhanced benefits. (AR at 06726 ("Enhancing fiscal sustainability allows the state to provide services to Medicaid beneficiaries that it could not otherwise provide.")

The final sustainability rationale endorsed by the Secretary was that Kentucky HEALTH enables the Commonwealth to continue participating in expanded Medicaid. (AR at 06726.) In its Section 1115 application from August 2016, Governor Bevin made clear that Kentucky HEALTH

was necessary to the Commonwealth's continued participation in expanded Medicaid. (AR at 5432 (stating that the status quo "is an expense Kentucky cannot afford without jeopardizing funding for education, pension obligations, public safety and the traditional Medicaid program for our most vulnerable citizens".)). Governor Bevin gave this conclusion the force of Kentucky law via executive order on the same day that the Secretary initially approved Kentucky HEALTH. (*See* ECF 25-1.) This executive order, which is self-executing, remains the law of Kentucky.

Plaintiffs' only response is to note that the Medicaid Act describes the expansion population as a "mandatory population." (ECF 91-1 at 4 ("[T]he population group nevertheless continues to be described as a mandatory coverage group in the Medicaid Act itself.").) Plaintiffs' argument appears to be that expanded Medicaid becomes forever mandatory once a state opts in. This is so, apparently, even for a state like Kentucky that expressly noted that its decision to participate in expanded Medicaid could be revoked. (ECF 50-3 at 2.) Plaintiffs' argument is irreconcilable with *NFIB*, *supra*. Under Plaintiffs' theory, a state that desires to leave expanded Medicaid faces the same unconstitutional choice invalidated in *NFIB*: "They must either accept a basic change in the nature of Medicaid, or risk losing all Medicaid funding." *NFIB*, 567 U.S. at 587. *NFIB* expressly noted that financial concerns were enough for a state to reject expanded Medicaid in the first instance: "States may choose to reject the expansion; that is the whole point . . . . Some States may indeed decline to participate . . . because they are unsure they will be able to afford their share of the new funding obligations . . . ." *Id.*

The previous and current administrations agree that Kentucky can leave expanded Medicaid if it so chooses. In the wake of *NFIB*, CMS repeatedly made clear that states were free, in their discretion, to leave expanded Medicaid after initially expanding. First, in December 2012, CMS stated that "[a] state may choose whether and when to expand, and, if a state covers the

expansion group, it may decide later to decide to drop the coverage." *See Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 12. Second, in August 2012, CMS repeated this conclusion and further concluded that "states have flexibility with respect to whether and when to start or stop the expansion . . . ." CMS Letter to Governor Beebe, at 1 (Aug. 31, 2012), ECF 72-2.

The Secretary repeated this conclusion in approving Kentucky HEALTH, explaining that "any potential loss of coverage that may result from a demonstration is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA adult expansion population." (AR at 06731.) This is perhaps the most compelling sustainability rationale supporting Kentucky HEALTH. With Kentucky HEALTH, Kentucky can afford to continue providing expanded Medicaid, plus the enhanced benefits that are part of Kentucky HEALTH. Without Kentucky HEALTH, the Governor's executive order will take effect. Surely keeping expanded Medicaid in the form approved in Kentucky HEALTH is more likely to assist in advancing the objectives of Medicaid in Kentucky than not having any form of expanded Medicaid at all.

(C) Achieving independence as an objective of Medicaid. The Secretary also determined that "Kentucky HEALTH, working in coordination with KY HEALTH, is . . . likely to promote the objective of helping beneficiaries attain or retain financial independence." (AR at 06724.) This program, the Secretary reasoned, "will help the Commonwealth and CMS evaluate whether the community engagement requirement helps adults in Kentucky HEALTH transition from Medicaid to financial independence, thus reducing dependency on public assistance." (AR at 06724-06725.)

The Secretary noted that the previous administration also endorsed independence-based proposals under Section 1115. (AR at 06724.)

Plaintiffs claim that helping able-bodied Medicaid enrollees achieve financial independence is not an objective of Medicaid. (ECF 91-1 at 14.) They take the extreme position that Medicaid is altogether unconcerned with whether able-bodied persons stay on governmental assistance forever, even if they have the ability to move beyond it. Plaintiffs ground this argument in Section 1396-1, but that provision does not purport to be the end-all-be-all for the objectives of expanded Medicaid. Section 1396-1 does not include the word "objectives," nor does it cross-reference Section 1115. In fact, Section 1396-1 notes that appropriations for Medicaid have other "purposes" than the two listed in Section 1396-1. *See* 42 U.S.C. § 1396-1 (appropriating sums "to carry out the purposes of this subchapter," not merely the two purposes listed in that provision).

The text of Section 1396-1 makes clear that it does not list the universe of "purposes" for appropriations for expanded Medicaid. Section 1396-1 lists just four categories of persons who are governed by it: those who are "aged, blind, or disabled" and "families with dependent children." 42 U.S.C. § 1396-1; *see NFIB*, 567 U.S. at 583 ("The original [Medicaid] program was designed to cover medical services for four particular categories of the needy . . . ."). These four categories of persons, of course, are not part of expanded Medicaid. The Medicaid expansion, as *NFIB* explained, is a "*new* health care program" designed "to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *Id.* at 583–84 (emphasis added). Thus, because Section 1396-1 speaks only to the four populations covered by traditional Medicaid, it has nothing to say about the "purposes" of expanded Medicaid.

In any event, Section 1396-1 recognizes that, for the four listed populations, Medicaid appropriations are to provide "rehabilitation and other services to help such families and

individuals attain or retain capability for *independence* or self-care." 42 U.S.C. § 1396-1 (emphasis added). Plaintiffs do their best to minimize Section 1396-1's use of the word "independence." According to Plaintiffs, "independence" means "functional (not financial) independence—*i.e.*, the capacity to accomplish the activities of daily living, such as feeding, dressing, and bathing." (ECF 91-1 at 14.) The Court mentioned a similar line of reasoning in its opinion, explaining that Section 1396-1 "quite clearly limits its objectives to helping States furnish rehabilitation and other services that might promote self-care and independence." *Stewart*, 313 F. Supp. 3d at 271. Respectfully, if the Court were interpreting Section 1396-1's use of "independence" as applied to traditional Medicaid populations, this reasoning might carry weight. But the Court is not asked to apply that term to the traditional Medicaid populations.

Instead, the Court is tasked with determining whether independence is an appropriate objective of Medicaid vis-à-vis the expanded Medicaid population. As noted above, this population is not mentioned in Section 1396-1. At a minimum, this means that Section 1396-1 is ambiguous, warranting *Chevron* deference to the Secretary on this point. Importantly, the able-bodied members of the expanded population—the primary focus of Kentucky HEALTH—are altogether unlike the four populations mentioned in Section 1396-1 (the aged, blind, disabled, and families with dependent children). "Independence" for those four populations and what they need to attain it is quite different from "independence" for the expanded Medicaid population and what they need to attain it.

Plaintiffs, as discussed above, interpret "independence" to mean "feeding, dressing, and bathing." (ECF 91-1 at 26.) That definition conceivably makes sense for the aged, blind, and disabled, and perhaps for a few families with dependent children. But this definition makes no sense whatsoever for able-bodied members of expanded Medicaid who can feed, dress, and bathe

regardless of whether they receive Medicaid. "Independence" for the able-bodied participants in expanded Medicaid means, among other things, learning healthy behaviors, engaging in their communities, finding meaningful work, getting the skills and education they need, and successfully transitioning to commercial coverage, i.e. being "independent" in ways in which they are not already.

Nor does the line of reasoning discussed by the Court overcome this problem. As discussed above, the Court focused on Section 1396-1's use of "rehabilitation and other services" as the means for achieving "independence or self-care." *See Stewart*, 313 F. Supp. 3d at 271. However, able-bodied individuals generally do not need "rehabilitation and other services" to achieve "independence or self-care." In light of the difficulty of applying this provision to a population not mentioned in Section 1396-1 that is wholly unlike the populations that are mentioned there, it is correct for the Secretary to conclude that he can pursue the purpose mentioned in Section 1396-1—independence—by means suited to the able-bodied members of expanded Medicaid.

Kentucky's experience with expanded Medicaid demonstrates the importance of independence being an objective of Medicaid for able-bodied enrollees. As Kentucky explained in its waiver application, in any given year, a significant number of Kentucky Medicaid recipients "churn" back and forth between Medicaid and commercial coverage. More specifically, Kentucky relied on data estimating that "approximately half of adults with income below 200% FPL will move between Medicaid eligibility and Marketplace coverage at least once a year, while 25% will move between the two programs more than once." (AR at 5444.) More recent data bear this out. Over the recent economic upturn, Kentucky's enrollment in expanded Medicaid has naturally decreased as wages have increased, dropping from 490,668 to 450,008, or 8.3%, during the one-year period of December 17, 2017 to December 17, 2018 (Affidavit of Steve Bechtel, attached as

Exhibit "A"). This is in contrast to Kentucky's traditional Medicaid numbers, which decreased by only 2.3% during that same period. *Id*. This data demonstrates the importance of achieving independence as an objective for the Medicaid expansion population. Because participation in expanded Medicaid is specifically tied to income, it makes sense to treat expanded Medicaid as a transition program, at least in part, given the inevitable fluctuations in the economy. Consistent with this theme, independence-based initiatives, like Kentucky's community-engagement program, are properly viewed as an important tool for states to help transition low-income, able-bodied persons to the workplace when jobs are plentiful. This allows states, and the federal government for that matter, to preserve valuable resources during good economic times and thus have the ability to weather difficult economic times when Medicaid expansion enrollment naturally will increase. In short, having independence as an objective is intrinsic to a program, like expanded Medicaid, that is specifically tied to income.

This interpretation of "independence" is further bolstered by 42 U.S.C. § 1396u-1(b)(1)(3)(A), which permits termination of Medicaid benefits to those individuals who have had TANF benefits terminated "because of refusing to work." Plaintiffs contend that it is somehow "revealing" because Congress, when it inserted this provision, did not take the opportunity to amend the Medicaid Act to permit work requirements generally. (ECF 91-1 at 36.) But this misses the point entirely. The question is simply whether work (or in the case of Kentucky HEALTH, the much more easily satisfied community engagement requirement) is "likely to assist in promoting the objectives" of Medicaid as required by Section 1115. Congress has clearly acknowledged that it does promote those objectives through its enactment of 42 U.S.C. § 1396u-1(b)(1)(3)(A), regardless of whether it chose to apply a work requirement to Medicaid generally. The only alternative is the nonsensical conclusion that 42 U.S.C. § 1396u-1(b)(1)(3)(A), which is within the

Medicaid Act, is inconsistent with the objectives of the Medicaid Act itself. Moreover, the population targeted by that statute (able-bodied TANF recipients) is in most respects identical to those required to participate in community engagement under Kentucky HEALTH.

Finally, Section 1115 AFDC waivers requiring or incentivizing work have been approved under statutory language remarkably similar to that in 42 U.S.C. § 1396-1. In *Aguayo v. Richardson, supra*, the Second Circuit had before it a waiver that mandated up to forty hours a week of work, with refusal to participate being grounds for termination of benefits. *Aguayo*, 473 F.2d at 1094-95. The waiver was challenged as being beyond the objectives of the legislation:

> Appellants argue that the objective of federal participation in the AFDC program, as stated in 42 U.S.C. § 601, is to assist the states "to furnish financial assistance and rehabilitation and other services" which will encourage "the care of dependent children in their own homes or in the homes of relatives"–not to force their parents or relatives, or themselves, to work.

Id. at 1103. Judge Friendly rejected this argument, pointing out that the statutory objectives also included a reference, as here, to "independence":

> This takes too narrow a view of Congress' purpose. To begin, Congress must have realized that extension of assistance to cases where parents, relatives or the child himself was capable of earning money would diminish the funds available for cases where they were not… Beyond that, 42 U.S.C. § 601 itself states as one of the purposes of the program "to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection . . . ."

Id. at 1103-04; *see also*, *C.K. v. N.J. Dept. of Health and Human Servs.*, 92 F.3d at 184 (upholding secretary's approval of Section 1115 wavier which included work incentive on grounds that it satisfied statutory objective of "self-support and personal independence.").

(D) The 95,000 figure. The Secretary also went to great lengths to fully consider the issue raised in the Court's decision to vacate and remand the Secretary's approval of Kentucky HEALTH. With respect to the 95,000 figure, the Secretary concluded that, "it is not accurate to assume, as some commenters did, that this study reflects that 95,000 individuals will completely

lose coverage and not regain it." (AR at 06731.) The Court's decision noted that "[a]mici maintain that [the 95,000 figure] is conservative and peg the real figure as between 175,000 and 297,500." *Stewart*, 313 F. Supp. 3d at 262. However, figures, which are projections based upon SNAP enrollment (ECF 44 at 17, 31-32.), as opposed to Medicaid enrollment, are an apples-to-oranges comparison and not relevant to this matter.

Kentucky designed Kentucky HEALTH to enable enrollees to graduate up to commercial coverage. (AR at 6724-6725.) The core components of Kentucky HEALTH—to name a few, the *My Deductible* account, the premium requirement, the community-engagement requirement—were specifically structured to help able-bodied individuals move beyond Medicaid and not revert back. Thus, even if it is accurate to assume that 95,000 individuals will lose Medicaid coverage as a result of Kentucky HEALTH (it is not, for the reasons described below and in the Secretary's waiver approval), Kentucky HEALTH is designed to test whether a number of those individuals will be otherwise covered through commercial coverage. (AR at 06725.)

Even putting that aside, the 95,000 figure does not actually approximate the number of people who will lose Medicaid coverage because of Kentucky HEALTH. As the Secretary noted, the 95,000 projection was made *before* Kentucky HEALTH had "additional beneficiary guardrails expected to help beneficiaries maintain enrollment." (AR at 06729.) CMS described these guardrails in great detail in its post-remand approval letter.

> These guardrails, which are contained in a series of assurances in the STCs (described in STC 22, 24, 32 and 47), include requirements that the state; provide opportunities for re-enrollment before the end of the six month non-eligibility period for beneficiaries who meet certain requirements, screen beneficiaries and determine eligibility for other categories of Medicaid eligibility prior to a non-eligibility period, review for eligibility for insurance affordability programs prior to a non-eligibility period, provide full appeal rights prior to disenrollment, and maintain a system that provides reasonable modifications related to meeting the community engagement requirements to beneficiaries with disabilities, among other assurances. The STC's include a provision granting CMS the

> authority to discontinue the demonstration if the agency determines that it is not promoting Medicaid's objectives. Moreover, CMS will regularly monitor Kentucky HEALTH and will work with the Commonwealth to resolve any issues that arise as Kentucky works to implement the demonstration.

(AR at 06729.)

In addition, a projection about "member months"—the basis for the 95,000 figure—does not approximate how many people will lose Medicaid coverage. As the Secretary noted, a decrease in "member months" is tied, at least in part, to the fact that Kentucky HEALTH includes a waiver of retroactive coverage. (AR at 06731) The "member month" projection does not accurately estimate coverage loss for the further reason that, under Kentucky HEALTH, a member may temporarily lose coverage for program non-compliance but regain coverage shortly thereafter. (*See* AR at 06731.)

Furthermore, as the Secretary noted, Kentucky HEALTH is not designed to cause individuals to lose coverage. (AR at 06731("This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the incentives included in this demonstration are not designed to encourage this result.")). To the contrary, Kentucky HEALTH contains numerous "guardrails" and "on ramps" that limit coverage loss and facilitate a quick return to coverage for those who lose it. (See generally AR at 06729.) Also, the program requirements that Plaintiffs claim will cause coverage losses are there to provide benefits to enrollees who choose to comply with those requirements. (AR at 06731 ("To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence.")).

In any event, Section 1115 itself recognizes that coverage losses may occur as a result of a demonstration project. *See* 42 U.S.C. 1315(d)(1) ("An application . . . of any experimental, pilot,

or demonstration project undertaken under subsection (a) . . . that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under subchapter XIX . . . shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2)"). The Secretary reasonably concluded that any loss in coverage must be balanced against the expected benefits of Kentucky HEALTH. (AR at 06731 ("[A]ny loss of coverage as the result of noncompliance must be weighed against the benefits Kentucky hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the Commonwealth's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.")), The Secretary also reasonably recognized that any loss in coverage caused by Kentucky HEALTH must be weighed against the expected loss in coverage if Kentucky exercises its discretion to leave expanded Medicaid. (AR at 06732 (concluding that any loss in coverage from Kentucky HEALTH "is likely dwarfed by the 454,000 newly eligible adults who stand to lose coverage if Kentucky elects to terminate the non-mandatory ACA expansion")).

One final point: Any coverage losses associated with Kentucky HEALTH must be considered in conjunction with *enhanced coverage* that Kentucky HEALTH allows Kentucky to offer to enrollees. (AR at 06731 ("We also note that the demonstration provides coverage to individuals that the state is not required to cover.")). Under Kentucky HEALTH, Kentucky offers beneficiaries services that are optional under the Medicaid Act—namely, dental and vision benefits and coverage for over-the-counter prescriptions. (AR at 06721.) Not only that, but the Commonwealth even offers benefits that are not normally covered through Medicaid via Kentucky HEALTH and KY HEALTH, like certain fitness-related benefits and SUD coverage. (AR 06726.)

II. Plaintiffs' arguments about the scope of Section 1115 and Medicaid's objectives are demonstrably wrong.

A. Section 1115 is not just for tinkering around the edges Medicaid.

Plaintiffs claim that the Secretary has "sought to rewrite the Medicaid Act in a way that is contrary to the program's purpose" through Kentucky HEALTH, which they claim is inconsistent with the text of Section 1115. (Doc. 91-1. at 13.) However, Section 1115, as written, plainly contemplates waivers that are big, small, and anywhere in between. It allows the Secretary to **waive** "*any* of the requirements of section . . . 1396a." 42 U.S.C. § 1315(a)(1) (emphasis added). It does not, as Plaintiffs contend, say that the Secretary can only waive requirements as long as the Secretary modifies Medicaid around the edges.

Plaintiffs base their argument on *MCI Telecommunications Corp. v. American Telephone & Telephone Co.*, 512 U.S. 218 (1994). (ECF 91-1 at 37.) Their reliance on this case shows just how wrong they are. That case was not a Section 1115 case; it instead dealt with a statute that allowed an agency to "modify any requirement" of the statute. *Id.* at 224. Obviously, allowing an agency to "modify any requirement" of a statute is altogether different from enabling the Secretary to "waive compliance with any of the requirements" of a statute. As the *MCI Telecommunications* Court explained, "[t]he word 'modify'—like a number of other English words employing the root 'mod' . . . such as 'moderate,' 'modulate,' 'modest,' and 'modicum'—has a connotation of increment or limitation. Virtually every dictionary we are aware of says that 'to modify' means to change moderately or in minor fashion." *Id.* at 225. The word "waive," by contrast, is not inherently limited in any way. To "waive" something is "to refrain from pressing or enforcing it" or to "dispense with" it. *Webster's Third Int'l Dictionary* 2570 (1976). Whereas the word "modify" has a "connotation of increment or limitation" built into it, the word "waive" does not.

Plaintiffs also press the argument that "waiv[ing] any of the requirements" of Medicaid, as Section 1115 permits, does not allow the Secretary to modify, amend, or change statutory provisions. (ECF 91-1 at 46.) Their argument appears to be that waiver is an on-off proposition and that the Secretary has gone beyond that by approving a new program. Plaintiffs can cite no court decision that has interpreted Section 1115 this way. With good reason. Section 1115 envisions a state submitting an "experimental, pilot, or demonstration project" to the Secretary, which the Secretary can then approve by waiving contrary provisions of the Medicaid statute as necessary. *See Phoenix Baptist Hosp. & Med Center v. United States*, 728 F. Supp. 1423, 1428 (D. Ariz. 1989), *aff'd* 937 F.2d 452 (9th Cir. 1991) ("The Secretary's decision to waive requirements involves a policy decision to allow a state the opportunity to develop its own alternative to traditional medicaid programs which can provide information helpful to furthering the objectives of the Medicaid program.").

One final point: Plaintiffs' cramped view of the Secretary's waiver authority—namely, that it is just for tinkering with Medicaid—is incompatible with how Section 1115 has been interpreted for decades. For example, Arizona's entire Medicaid program has operated under a Section 1115 waiver since 1982.[3] Tennessee and Rhode Island likewise have received global Section 1115 waivers to operate their Medicaid programs.[4] Compared to these global waivers, Kentucky HEALTH is modest. In addition, states have used Section 1115 waivers to accomplish far more

[3] Schubel, Senate Health Bill Would Penalize Arizona for Its Innovative and Efficient Medicaid Program (July 19, 2017), *available at* https://www.cbpp.org/research/health/senate-health-bill-would-penalize-arizona-for-its-innovativ e-and-efficient-medicaid (last visited Feb. 4, 2019).

[4] Tennessee Approval & STCs, at 12 (Feb. 1, 2018), *available at* https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf (last visited Feb. 4, 2019); Rhode Island Comprehensive Demonstration STCs, at 10 (Oct. 20, 2016), *available at* http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/1115Waiver/RISTCswTCs120216.pdf (last visited Feb. 4, 2019).

fundamental changes to Medicaid than Kentucky HEALTH. Arkansas, for example, expanded Medicaid by using a Section 1115 waiver, under which Medicaid expansion enrollees are placed into private insurance plans, rather than receiving Medicaid.[5] The takeaway is clear: If Plaintiffs' constrained view of the Secretary's waiver authority is sustained, which would be a judicial first, the Court will call into question decades of Section 1115 waivers, many of which are in place now.

B. Plaintiffs merely disagree with the Secretary's "judgment" and all approved waiver provisions contained a rational basis.

Plaintiffs devote substantial effort to simply arguing with the Secretary's "judgment." For example, Plaintiffs claim that his judgment is "wrong" (ECF 91-1 at 31) and is "undercut" by comments (*id.* at 33). They also repeatedly fault the Secretary for not citing evidence showing that some or all of Kentucky HEALTH's component will actually accomplish the objectives that the Secretary has identified.

(1) A rational basis exists supporting the approval of the community engagement program.

In arguing that the Secretary lacked a rational basis to approve Kentucky HEALTH's community-engagement program, Plaintiffs proffer mostly policy-based objections. They devote their arguments in large part to the alleged consequences of imposing what they incorrectly refer to as "work requirements." This is a straw-man tactic: Plaintiffs cannot validly claim that the Secretary lacked a rational basis with respect to a community-engagement program, so they make Kentucky HEALTH into something it is not, a work program.

Although Plaintiffs urge that a "work requirement" is refuted by comment after comment, the administrative record is replete with research that supports the Secretary's decision. (*E.g.*, AR

[5] Maylone, *et al.*, Evidence from the Private Option: The Arkansas Experience (Feb. 22, 2017), *available at* http://www.commonwealthfund.org/publications/issue-briefs/2017/feb/private-option-arkansas-experience (last visited Feb. 4, 2019).

4761, 4765–66, 4824–25, 4840–43, 5054–60, 5072–73, 5112–368, 5369–85, 5386–91, 5392–408.) Additionally, the Secretary's letter of November 20, 2018 approving Kentucky HEALTH following remand also cites numerous studies supporting the positive effect community engagement can have on health and wellness. (AR at 06733, fn. 9 and 10.) In this vein, CMS initially concluded that Kentucky HEALTH "is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that research has shown to be correlated with improved health and wellness." (AR at 4.) CMS expounded on this point in its January 11 letter. (AR at 91 (collecting sources).) Finally, in its post-remand approval letter, CMS stated as follows:

> CMS has reviewed and considered the research cited by commenters and notes that other research also shows a positive link between community engagement and improved health outcomes. None of the existing research, however, definitively shows whether a community-engagement requirement as a condition for continued Medicaid coverage will help beneficiaries attain financial independence and improve health outcomes. Thus, CMS has determined that it is appropriate to permit states to use section 1115 demonstration projects to determine whether they can achieve such an outcome using community engagement requirements.

(AR at 06733)

Faced with the inescapable fact that the Secretary has the clear authority to approve a demonstration project, the Plaintiffs attempt to argue that Kentucky HEALTH is doomed to failure based on highly preliminary data from the first two months of Arkansas' demonstration project. (ECF 91-1 at 33-34.) On its face, this is an absurd proposition; one demonstration project cannot be discredited by two months' worth of data from any entirely separate demonstration project. To suggest otherwise makes a mockery of the empirical process. Regardless, there is no indication that Arkansas' waiver contains safeguards comparable to the "guardrails" contained in Kentucky HEALTH. The Secretary noted that these protections would, among other things, "permit

beneficiaries to efficiently report community engagement hours" (AR at 06732), which addresses Plaintiffs' chief complaint about Arkansas' limited data. (See also, AR at 06729.) Therefore, any implications the Plaintiffs seek to draw from two months' worth of wildly preliminary data form Arkansas are wholly irrelevant to this analysis and not worthy of the Secretary's consideration.

Ultimately, in the face of conflicting data, the Court need not wade into this social-science dispute. *See Richardson*, 348 F. Supp. at 498 ("This Court does not, however, function as a scientific critic . . . ."). The aforementioned body of research plainly gave the Secretary a rational basis to test a community-engagement program as likely to improve health outcomes, among other things. Plaintiffs' only rebuttal is to continue to insist that "the Secretary also failed to reasonably explain how the work requirement would promote Medicaid coverage for low-income individuals." ((ECF 91-1 at 34.) Nevertheless, the ultimate judgment, however, is vested with the Secretary, not the Plaintiffs or this Court. *See* 42 U.S.C. § 1315(a).

(2) A rational basis existed supporting the approval of Kentucky HEALTH's premium requirements.

Plaintiffs also claim that the Secretary lacked a rational basis to approve premiums as part of Kentucky HEALTH. As Kentucky explained in its waiver application, in any given year, a significant number of Kentucky Medicaid recipients "churn" back and forth between Medicaid and commercial coverage. More specifically, Kentucky relied on data estimating that "approximately half of adults with income below 200% FPL will move between Medicaid eligibility and Marketplace coverage at least once a year, while 25% will move between the two programs more than once." (AR at 5444.) Part of Kentucky's hypothesis, which the Secretary agreed in the initial approval of Kentucky HEALTH was worth testing in light of the above-cited data, is that Kentucky HEALTH enrollees need to experience the unique aspects of marketplace coverage to decrease the churn rate between commercial coverage and Medicaid. (AR at 6, 5444.)

The Secretary made similar findings in the approval following remand. "It is designed to test whether these beneficiaries will be encouraged to obtain and maintain health coverage, even when healthy, and whether there will be a reduction in gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick." (AR at 06724.)

Plaintiffs make much of studies that, in their view, show that previous Section 1115 demonstration projects with premiums have caused a significant loss in coverage. "During the most recent comment period, several dozen commenters cited the numerous studies, conducted over the course of almost two decades, that examine the effects of imposing premiums on low-income individuals enrolled in Medicaid and similar publicly funded insurance programs. (ECF 91-1 at 34.) To begin with, none of the studies the Plaintiffs cite here actually appear to be in the administrative record, as opposed to merely being referenced in the record.[6] This is not enough. *See Marcum*, 751 F. Supp. 2d at 80; *Cape Hatteras Pres. Alliance*, 667 F. Supp. 2d at 114.

Plaintiffs principally rely on Indiana's recent experience with premiums in which they say "monthly premiums and associated consequences will deter and reduce enrollment in Kentucky HEALTH, leaving many low-income individuals uninsured." (ECF 91-1 at 23.) Here again, Plaintiffs' brief contains a mere reference to Indiana's data, not the actual data (Plaintiffs cite to AR at 19997-78 and AR at 16713-14 at ECF 91-1 at 35 which only reference data from Indiana). In any event, the Indiana data sharply undercuts Plaintiffs' position on premiums. Only 5 percent of participants in Indiana's program were dis-enrolled for non-payment of premiums.[7] Plaintiffs'

[6] The Plaintiffs cite studies referenced at AR at 19976, 15485, 26310-11 and 18613-14. None of these referenced studies appear to be in the administrative record. In fact, this is a reoccurring trend on the Plaintiffs' part. Of the numerous studies referenced in the Plaintiffs' fn. 10, only two actually appear to be in the administrative record. Additionally, the study referenced in Plaintiffs' fn. 11 also does not appear to be in the administrative record.

[7] Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, at 10 (Mar. 31, 2017), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-

statement that 55 percent of Indiana enrollees failed to pay their premiums is deceptive, as enrollees for whom payment of a premium was optional accounted for 88 percent of the non-payers. POWER Account, at 8. In addition, while Indiana's data showed that 23 percent of enrollees did not make their initial premium payment, the data also suggested that half or so of those enrollees either reapplied for the program and paid the premium or were enrolled in another Medicaid category. *Id.* at 12, 22.

In addition to distorting the data about premiums and enrollment, Plaintiffs fail to mention a crucial aspect of Indiana's data about premiums, which is in the administrative record. As Kentucky explained in its waiver application, premiums in Indiana have been positively correlated with healthy behavior:

> [P]remium payments are critical to member engagement, as studies have shown that making regular monthly premiums may actually lead to better health outcomes for members. In Indiana, where Medicaid eligible adults are required to pay monthly premiums equal to 2% of income, members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher drug adherence, and lower emergency room use than those who did not.

(AR 5464–65; *see also, e.g.*, AR 4934, 4947 (providing this data)). All of this goes to show that Plaintiffs' views about the negative effects of premiums are strongly contested in the administrative record. Instead of acknowledging this fact, the Plaintiffs cynically suggest that any sort of experimentation within the confines of a demonstration project regarding premiums is a wasted effort, as the results will always be the same. (ECF 91-1 at 36.). Such an assumption clearly disregards the clear statutory authority found at 42 U.S.C. § 1315 allowing the Secretary to approve waivers for experimental or demonstration projects.

Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf (last visited Feb. 4, 2019).

Regardless, the Secretary took at least two specific steps to respond to concerns about premiums and coverage. *First*, in its original approval letter, CMS noted that Kentucky HEALTH limits dis-enrollment due to premium non-payment by providing an "'on-ramp' that enables these individuals [*i.e.*, those who lose coverage due to non-payment of premiums] to regain eligibility and successfully access all of the benefits, resources, and tools of the Kentucky HEALTH program, without waiting until the end of the non-eligibility period." (AR at 7.) This refers to Kentucky HEALTH's early re-enrollment process, which allows an enrollee who loses coverage due to premium non-payment to re-enroll, once a year, *before* his six-month ineligibility period runs. (AR at 41.) This early-enrollment process minimizes the number of enrollees who will lose coverage for any meaningful length of time for failing to pay premiums. These sentiments were echoed in the approval letter following remand. "However, these beneficiaries will have a one-time opportunity, per year, to re-enter the program before the end of the non-eligibility period if they attend an early re-enrollment course and pay the premium required for the first month of re-entry. (AR 06734 and see AR 06772-06773.).

Second, so as to limit the number of individuals who lose coverage due to non-payment of premiums, CMS noted in its initial approval of Kentucky HEALTH that "Kentucky has taken steps to protect beneficiaries [from being dis-enrolled due to premium nonpayment] by exempting certain vulnerable populations, such as pregnant women and individuals who are medically frail . . . as well as by allowing temporary good cause exemptions in certain circumstances . . . ." (AR at 7.) Following remand, this category of individuals exempt from premium requirements was expanded to include survivors of domestic violence and beneficiaries who are eligible for transitional medical assistance as described in sections 1925 and 1931(c)(2). (AR at 06769.)

In in the post-remand approval letter, CMS observed that, "Kentucky designed the premium requirement in a way that minimizes potential impacts on beneficiaries. The premiums requirement is designed to align requirements in the commercial insurance market, but also provides opportunities for beneficiaries to avoid the consequences of nonpayment if they can demonstrate they had a good cause for not meeting their premium obligation." (AR at 06734). Furthermore, Kentucky does not require enrollees under 100 percent of FPL to pay their premiums, further decreasing the likelihood that enrollees will be dis-enrolled for not paying their premiums. (AR at 06773.)

Ultimately, the Secretary's burden in responding to comments in the administrative record is not "particularly demanding." *Cooper Hosp.*, 179 F. Supp. 3d at 54 (quoting *Public Citizen, Inc. v. F.A.A.*, 988 F.2d 186, 197 (D.C. Cir. 1993)); *see also C.K.*, 92 F.3d at 185 ("We will not assume that the Secretary ignored the materials presented in contravention of the state's position simply because, in the end, she was not persuaded by them."). The most relevant and significant pushback that the Secretary received related to premiums concerned how many enrollees will allegedly lose Medicaid coverage if premiums are imposed, a topic that, as already discussed, CMS directly addressed. *See Public Citizen*, 988 F.2d at 197. The 80-plus page approval package for Kentucky HEALTH more than enables the Court to "see what major issues of policy were ventilated . . . and why the agency reacted to them as it did." *Id.* (citation omitted).

(3) A rational basis exists supporting the Secretary's approval of Kentucky HEALTH's provisions dealing with retroactive coverage.

Plaintiffs also claim that the Secretary lacked a rational basis to approve a waiver of retroactive coverage. In originally approving this component of Kentucky HEALTH, CMS concluded that it "encourages beneficiaries to obtain and maintain health coverage, even when healthy. This is intended to increase continuity of care by reducing gaps in coverage when

beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick." (AR at 6.) In that original approval, CMS also observed that, by waiving retroactive coverage, Kentucky HEALTH mirrors commercial coverage, where enrollees receive coverage once it is initiated. (AR at 6–7.) CMS's easy-to-follow reasoning adequately establishes the Secretary's rational basis for waiving retroactive coverage.

CMS made additional findings in its letter approving Kentucky HEALTH following remand. In addressing concerns expressed in the comment period following remand, CMS specifically found that, "The waiver of retroactive eligibility is likely to help promote Medicaid's objectives in at least two ways: (1) it may improve uptake of preventive services and thus improve beneficiary health; (2) it improves the fiscal sustainability of the Medicaid program, which helps to permit Kentucky to continue to provide Medicaid to the ACA population, and to continue to cover non-mandatory benefits and eligibility groups." (AR at 06736).

CMS' reasoning in this matter could not be any more straightforward. By removing retroactive coverage, Kentucky HEALTH directly incentivizes individuals to retain constant Medicaid coverage, as opposed to churning off and onto such coverage on an as necessary basis. By putting forth a scheme that reinforces the need for the continuity of Medicaid coverage, Kentucky HEALTH clearly supports the Medicaid Act's purpose of promoting beneficiary health by "encourage[ing individuals] to make responsible decisions about their health and accessing health care…" (AR 06723-06724).

Plaintiffs argue that "waiving retroactive coverage will create gaps in coverage and reduce access to Medicaid services by weakening the network or providers serving enrollees." (ECF 91-1 at 37.) In support of this argument, Plaintiffs cite a portion of the administrative record that purports to suggest that eliminating retroactive coverage in Ohio would cost hospitals up to 2.5

billion dollars over a five-year period. Plaintiffs' claims in this regard as they concern Kentucky hospitals are speculative comments that are of limited relevance and require no response. *See Home Box Office, Inc*. v. F.C.C., 567 F.2d 9, 35 n.58 (D.C. Cir. 1977); *Public Citizen*, 988 F.2d at 197; *see also C.K*., 92 F.3d at 185. Nevertheless, the Commonwealth notes that the STCs adequately address any such issues.

Furthermore, it must be noted that any financial impact Kentucky HEALTH may or may not have on Medicaid providers is not a strictly relevant consideration. "We doubt, to begin with, that providers are intended beneficiaries (as opposed to mere incidental beneficiaries) of the Medicaid agreement, which was concluded for the benefit of the infirm whom the providers were to serve, rather than for the benefit of the providers themselves." *Armstrong v. Exceptional Childcare Ctr.,* Inc., 135 S.Ct. 1378, 1387, (2015) (*citing Pharmaceutical Research and Mfrs. of Am. v. Walsh*, 538 U.S. 644, 683, 123 S.Ct. 1855 (2003)).

To the extent that this Court previously held that, "restricting retroactive eligibility will, by definition, reduce coverage for those not currently on Medicaid rolls," the Commonwealth respectfully disagrees. *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2018). By removing retroactive eligibility, Kentucky HEALTH strongly encourages eligible individuals to obtain and maintain coverage, which is precisely the opposite of reducing coverage. As such, it was entirely rational for the Secretary to conclude that Kentucky HEALTH "may include [an] uptake of preventative services." (AR at 06736). Furthermore, as it applies to both this aspect of Kentucky HEALTH as well as all others:

> Ascertainment by actual demonstration whether [a theory] is true would itself be a legitimate objective. Moreover, as previously indicated, we think the Secretary could properly give weight to the fact that the programs were of limited duration and would remain under the on-going supervision (with the power to terminate approval) of HEW. Experience will be the best test of the

> reality of appellant's fears, and a strong showing would be required to demonstrate that the Secretary could not properly subject them to it.

Aguayo v. Richardson, 473 F.2d 1090, 1107 (Second Cir. 1973). The Secretary echoed these sentiments in her approval following remand. "As previously stated, however, CMS believes the features of this demonstration are worth testing to determine whether this is a more effective way to furnish medical assistance to the extent practicable under the conditions in Kentucky." (AR at 06729.) "Moreover, CMS will monitor the demonstration, and the STCs provided that CMS can amend or withdraw waivers or expenditure authority if it determines that continuing the demonstration would no longer be in the public interest or promote Medicaid's objectives.

The Plaintiffs suggest that, "there is no evidence in the record showing that low-income individuals decide not enroll in Medicaid because they are healthy…" (ECF 91-1 at 38.) However, the administrative record does contain evidence that would have led the Secretary to reach the conclusions he did on this particular issue. For example, "Medicaid is characterized by churning eligibility, meaning continuous enrollment, loss of coverage, and re-enrollment." (AR at 12820.)

Plaintiffs also maintain that the Secretary failed to respond to comments about how waiving retroactive coverage could create gaps in Medicaid coverage and could create financial problems for would-be enrollees. (ECF 91-1 at 38) Wrong. First, CMS already directly responded to these types of concerns in the original approval letter by stating that "where an individual experiences a period of non-eligibility, Kentucky is providing opportunities to return to eligibility"—*i.e.*, the early re-enrollment provisions discussed above. (AR at 9, 41.) Second, CMS further responded to any concerns about the lack of retroactive coverage by requiring automatic ex parte renewals for at least 75 percent of Kentucky HEALTH beneficiaries. (AR at 06757-06758.) This will minimize the number of enrollees with gaps in coverage. (*See* AR 5478–79.)

Finally, CMS recognized that any gaps in coverage and resulting financial burdens due to the lack of retroactive coverage would pale in comparison to what would occur if Kentucky "un-expanded" its Medicaid. (AR at 06732 ("But even assuming that Kentucky HEALTH would result in a 5 percent decrease in covered member months as compared to the number of member months covered without the demonstration, and even assuming that most of these individuals would not transition to commercial coverage, that figure is likely dwarfed by the 454,000 newly eligible adults who stand to lose coverage if Kentucky elects to terminate the non-mandatory ACA expansion.)). Thus, CMS approved a waiver of retroactive coverage with the recognition, at least in part, that the Commonwealth may well entirely discontinue its participation in expanded Medicaid without a waiver. *See Richardson,* 348 F. Supp. at 496.

(4) A rational basis existed supporting the Secretary's approval of Kentucky HEALTH's provisions dealing with periods of ineligibility for failure to comply with the redetermination process and other aspects of Kentucky HEALTH.

Plaintiffs also contest Kentucky HEALTH's consequences for enrollees who fail to participate in the redetermination process for Medicaid eligibility or who fail to timely report changes that affect Medicaid eligibility. Applicable law already requires enrollees to do both of these things. Kentucky HEALTH merely adds teeth to the existing requirements. Specifically, after failing to complete the redetermination process, Kentucky HEALTH enrollees will have an additional 90 days to rectify the problem before they are dis-enrolled from the program for up to six months, with allowance made for a good-cause exception and early re-enrollment. (AR at 06756.) As to the reporting requirement, Kentucky HEALTH enrollees must report changes affecting their Medicaid eligibility during the required reporting period to avoid losing Medicaid eligibility for up to six months, with allowance made for a good-cause exception and early re-enrollment. (AR at 06759-06760.)

The Plaintiffs fail to account for the specific findings made by the Secretary in the post-remand approval of Kentucky HEALTH. The Secretary recognized that 42 U.S.C. § 1396-1 specifically uses the language "as far as practicable under the conditions in such State." The Secretary found, as it concerns the periods of ineligibility, "CMS considered these provisions in the context of the whole demonstration and determined that the demonstration appropriately balances the Medicaid objectives of ensuring coverage and permitting states to furnish Medicaid 'to the extent practicable under the conditions of such state.'" In other words, the Secretary recognized that Kentucky's individual economic condition, as documented in Governor Bevin's executive order, necessitated the approval of Kentucky HEALTH so that expanded Medicaid services could continue to be provided in the state of Kentucky "to the extent practicable under the conditions of" the Commonwealth.

Additionally, in the letter approving Kentucky HEALTH post-remand, the Secretary spoke extensively about the "on-ramps" in Kentucky HEALTH that "enable these individuals to regain eligibility and successfully access all of the benefits, resources, and tools of the Kentucky HEALTH program, without waiting until the end of the non-eligibility period." (AR at 06725) It is unsurprising that the Plaintiffs do not appear to even pay lip service to these "on-ramps" in their criticism of what they incorrectly refer to as "administrative lockouts." (ECF 91-1 at 38)

Moreover, there is no genuine dispute as to whether the Secretary is entitled to *Chevron* deference in his analysis of the objectives of the Medicaid program. One of the objectives of the Medicaid program, as determined by the Secretary, is to enable each state to furnish medical assistance as far as practicable under the conditions in a given state. (AR at 06719) To that extent, the Secretary found that "Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program…" (Id.).

Therefore, it should come as no surprise that the Secretary determined, in considering and responding to the comments submitted, that the brief periods of ineligibility "are designed to incentivize program compliance and familiarize beneficiaries with the functioning of commercial insurance. These goals also further Medicaid's objectives by improving the financial stability of Kentucky's Medicaid program." (AR. at 06736.) As such, the improvement of the financial stability of Kentucky's Medicaid program allows Kentucky to furnish medical assistance as far as practicable, and the Secretary is entitled to deference in his findings that Kentucky HEALTH is a worthy experiment in this regard.

Plaintiffs additionally challenge the periods of ineligibility on the basis that, during the previous administration, the Secretary rejected Indiana's request for a waiver related to Medicaid's redetermination requirements. (ECF 91-1 at 39.) Whether or not to approve a waiver request is based upon "case-by-case, fact-based determinations," *Cooper Hosp*., 179 F. Supp. 3d at 51, and appropriately can be tied to "the political and sociological orientation or general policy, of the Administration then in power," *Richardson*, 348 F. Supp. at 496; *C.K*., 92 F.3d at 187. Thus, in light of the experimental, fact-based nature of waivers, Plaintiffs' reliance on the Secretary's reversal from Indiana to Kentucky does not add up to much.

Plaintiffs nonetheless claim that the Secretary did not adequately explain his shift from Indiana's denial to Kentucky's approval. All that the Secretary needed to do, however, was display awareness of the change, which he did (AR at 06725), and establish that "there are good reasons for the new policy," which he also did. See *Navarro*, 136 S. Ct. at 2126 (citation omitted).

As for the latter showing required under *Navarro*, CMS gave three primary reasons in its initial approval letter as to why it blessed Kentucky HEALTH's redetermination components as they concern periods of ineligibility: (i) it "strengthen[s] beneficiary engagement in their personal

health care plan" (AR at 5); (ii) it "encourages individuals to maintain compliance with beneficiary responsibilities requirements . . . that also protect program integrity" (AR at 6); and (iii) it helps enrollees understand what commercial coverage is like (AR at 7). As to why the Secretary approved Kentucky's application but not Indiana's, CMS explained in its initial approval letter that "this policy should be evaluated and is likely to support the objectives of Medicaid to the extent that it prepares individuals for a smooth transition to commercial health insurance coverage and ensures that resources are preserved for individuals who meet eligibility requirements." CMS reiterated these findings in its approval post-remand when it found that, "CMS now believes that this policy should be evaluated, because it is likely to support the objectives of Medicaid to the extent that it prepares individuals for a smooth transition to commercial health insurance coverage." (AR at 06725.) By preparing individuals for the transition to commercial health insurance coverage, the objectives of Medicaid are furthered as the financial sustainability of Kentucky's Medicaid program is protected, in addition to furthering the goal of independence for Medicaid beneficiaries. The foregoing explanations are more than enough to satisfy the requirements of *Navarro*.

Plaintiffs also claim that the Secretary did not adequately respond to the comments opposing Kentucky HEALTH's redetermination and reporting requirements in addition to claiming that the Secretary's decision was otherwise irrational based on the evidence submitted. As mentioned above, the Secretary's job in this regard is "not particularly demanding." *Cooper Hosp.*, 179 F. Supp. 3d at 54 (citation omitted). To the extent that the comments Plaintiffs point to are not speculative (*see Public Citizen*, 988 F.2d at 197), CMS adequately responded to any relevant and significant comments about any potential risks associated with consequences for enrollees who violate the longstanding reporting and redetermination requirements. See *Cooper*

Hosp., 179 F. Supp. 3d at 54; *see also C.K.*, 92 F.3d at 185. CMS's initial approval letter underscored how important early re-enrollment was to the Secretary's approval of Kentucky HEALTH. (AR at 5, 9.) In addition, the Secretary required an ex parte re-approval rate of at least 75 percent, which further responds to the comments cited by Plaintiffs. (AR at 06757-06758.) These aspects of the Secretary's reasoning constitute a more than adequate response to the comments in question and otherwise satisfy a rational basis analysis. *See Cooper Hospital*, 179 F. Supp. 3d at 54; *Public Citizen*, 988 F.2d at 197; *C.K.*, 92 F.3d at 185.

(5) A rational basis existed supporting the Secretary's approval of Kentucky HEALTH's provisions dealing with Non-Emergency Medical Transportation.

Plaintiffs also challenge the Secretary's waiver of Medicaid's NEMT requirements. Similar waivers have been approved in Indiana and Iowa. *See* Musumeci, *et al.*, Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers (Mar. 8, 2018), *available at* https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/ (last visited Feb. 4, 2019). Kentucky requested a waiver of NEMT requirements, in part to allow enrollees in Kentucky HEALTH to experience something like the commercial marketplace, which does not offer NEMT. (AR at 06735.) The Secretary had a rational basis to approve NEMT as part of the larger package of components of Kentucky HEALTH that mirror a commercial experience. (AR at 06735.) The Plaintiffs claim that the Secretary's analysis focused only on the non-vulnerable population (ECF 91-1 at 40); however, the plain language of the post-remand approval letter directly refutes this contention. The Secretary clearly considered the impact on non-vulnerable populations. "Some commenters expressed concerns that the NEMT waiver for the new adult group will negatively impact Medicaid's recipients in rural areas who lack consistent transportation options." (AR at 06735.) In evaluating these considerations, the Secretary

determined that, "the benefit of offering NEMT to the new adult group is outweighed by enhancements to programmatic sustainability and the value of the optional services that Kentucky will offer. (Id.)

The Secretary's decision regarding NEMT was also supported by additional documentation in the administrative record. In fact, data in the administrative record shows that those without NEMT actually miss fewer medical appointment than those with NEMT, which clearly supports the Medicaid program's objective to provide medical services. In Indiana, only 6 percent of those without NEMT reported missing a medical appointment because of transportation, while 10 percent of those with NEMT reported missing a medical appointment because of transportation. (AR 4908.) Kentucky also specifically raised these points in its waiver application. (AR 5478.).

Plaintiffs also argue that Kentucky will lose money as a result of the removal of NEMT benefits. (ECF 91-1 at 40.) To that end, the Plaintiffs cite a study found in the administrative record. The study's thesis is as follows:

> The financial benefit of NEMT is likely to be shown most clearly in the costs avoided due to increased utilization of lower cost medical services (i.e., physician appointments) to increase adherent treatment care. The theory goes: missed medical appointments lead to deviations from clinical guidelines which, in turn, lead to complications and increased expensive medical services, such as hospitalizations.

(AR at 20717) However, the record also contains contrary evidence which suggests that individuals are less likely to miss medical appointments when they do not have access to NEMT as opposed to when they do have access. (AR at 4908.) It is the clear prerogative of the Secretary to weigh the evidence in the administrative record and to exercise reasoned judgment in the process of drawing his conclusions.

III. The Secretary had authority to approve the requirements of Kentucky HEALTH.

A. The Secretary had authority to approve Kentucky HEALTH's community-engagement program.

Plaintiffs challenge what they call Kentucky HEALTH's "work requirements" without fully explaining what they actually do. (ECF 91-1 at 33-35, 46-50.) To be clear, Kentucky HEALTH does not contain "work requirements." Kentucky HEALTH instead has a community-engagement program, and performing 80 hours of work per month is one of many ways that enrollees can become engaged in their communities. (AR at 06774-06775.) Enrollees also can satisfy the community-engagement requirement by doing 80 hours per month of any one or combination of the following: job-skills training; job-search activities; education related to employment; general education; vocational education and training; community work experience, community service, or public service; caregiving services for a non-dependent relative or other specified person; or participation in substance use disorder treatment. (Id.)

Plaintiffs also fail to mention that Kentucky HEALTH goes out of its way to exclude all but the able-bodied from its community-engagement initiative. Those exempt from the community-engagement program include: pregnant women; primary caregivers of a dependent; those who are medically frail; those who are "diagnosed with an acute medical condition that would prevent them from complying with the requirements"; full-time students; former foster care youth; and enrollees under the age of 19 or over the age of 64. (AR at 06774.). Kentucky HEALTH also contains a good-cause exemption from the community-engagement requirement. (AR at 06776). These numerous, careful exclusions confirm a simple point: Kentucky HEALTH's community-engagement initiative only applies to the most able-bodied participants in Medicaid.

Plaintiffs claim that allowing community-engagement requirements exceeds the Secretary's Section 1115 waiver authority. Their lead argument is that "the central purpose of the

statute is to provide medical assistance to low-income individuals" and that "Congress knows how to include work requirements when it wants to, and chose not to include them in Medicaid." (ECF 91-1 at 46-47.) Their primary evidence is two recent bills introduced in Congress that contained work requirements but failed to pass. These proposed bills are the American Health Care Act, H.R. 1628, 115th Cong., § 117 (2017) (This bill was a comprehensive proposal of which work requirements were a very small part); and the Medicaid Reform & Personal Responsibility Act of 2017, S. 1150, 115th Cong. (2017). These proposed bills, however, are irrelevant to the Secretary's authority to approve Kentucky HEALTH. For one thing, they contained work requirements different in many respects from Kentucky's community-engagement program. And more importantly, the Supreme Court has held that "failed legislative proposals are 'a particularly dangerous ground on which to rest an interpretation of a prior statute.'" *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps. of Eng'rs*, 531 U.S. 159, 169–70 (2001) (citation omitted).

Next, Plaintiffs claim that Kentucky HEALTH's community-engagement requirements are unlawful simply because SNAP and TANF both mention work requirements, whereas the Medicaid statute does not. (ECF 91-1 at 47.) However, Plaintiffs are confusing the inquiry. The question is not whether the Medicaid statute as currently written contains a work requirement or a community-engagement requirement. The applicable question is whether Section 1115 permits a waiver of Medicaid's requirements for a community-engagement trial run.

If anything, the work requirements in SNAP and TANF bolster the Secretary's decision to approve Kentucky HEALTH's community-engagement program. As Plaintiffs acknowledge, before 1996, neither SNAP nor TANF contained work requirements. Those work requirements came about as part of the welfare reform package that President Clinton signed in 1996. *See* Personal Responsibility & Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193,

110 Stat. 2105 (1996). Important for present purposes, prior to 1996, many states had received waivers—issued under Section 1115—to allow work requirements in TANF's predecessor program, AFDC. These pre-1996 waivers were an impetus for enacting welfare reform in 1996:

> Growing dissatisfaction with AFDC . . . led an increasing number of states to seek waivers from the AFDC rules. These waivers were mostly designed to allow states to more stringently enforce work requirements for welfare recipients. Such waivers had started under President Ronald Reagan, but the Clinton Administration actively encouraged more expansive statewide waiver programs. As a result, by the time [the 1996 welfare reform] passed, 27 states had major state-wide waivers in place.

Blank, Evaluating Welfare Reform in the United States, *Journal of Economic Literature*, Vol. 40, No. 4, at 1106 (Dec. 2002). Indeed, these pre-1996 waivers "were a major reason why policymakers supported work-oriented welfare reforms in the 1990s." *Id.* at 1122. That is, the states' experimentation with AFDC work requirements in the 1980s and 1990s led to Congress's passage of work requirements for TANF and SNAP in 1996.

This is an important point. Waivers allow states to experiment with innovative programs, and they allow others, including Congress, to track the success or failure of those programs while considering permanent changes to Medicaid. The 1996 changes to SNAP and TANF demonstrate that work requirements have been tested through waivers before and have culminated in real policy changes. Thus, the two failed bills mentioned by Plaintiffs, which show that at least some members of Congress are actively considering work or community-engagement requirements, actually underscore the necessity of a Section 1115 waiver like Kentucky HEALTH.

Plaintiffs also argue that Kentucky HEALTH's community-engagement program is unlawful because it is unprecedented. However, this does not account for the fact that, for nearly fifty (50) years of Medicaid's history, expanded Medicaid did not exist. As discussed, the Medicaid expansion was a sea change for Medicaid, bringing into the program an entirely new class of enrollees. *See Sebelius*, 567 U.S. at 583–84. From 1965 until the Medicaid expansion, Medicaid

served primarily only "four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children." *Id.* at 584. In light of the demographics of this population, it should come as no surprise that the Secretary did not approve a mandatory work requirement from 1965–2014.

Plaintiffs further note that, during the prior administration, the Secretary denied several waiver requests to impose work requirements on Medicaid recipients. (ECF 91-1 at.49 n.11.) These denials, Plaintiffs urge, undermine the deference owed to the Secretary's decision to approve Kentucky HEALTH. This is wrong for at least four reasons.

First, because expanded Medicaid became effective in 2014, the prior administration was the first one to interpret Section 1115 as it applies to the Medicaid expansion population. The prior administration is not entitled to a monopoly on the meaning of Section 1115, especially in light of the discretion afforded to the Secretary. As one district court has held, "it seems quite plain that the sort of experimental projects which are going to be approved [under Section 1115] may be much more closely related to the political and sociological orientation or general policy, of the Administration then in power than with its understanding of what the statute authorizes." *Richardson*, 348 F. Supp. at 496.

Second, this Court has held that the Secretary's decisions regarding Section 1115 waivers are "case-by-case, fact-based determinations" in which "courts appropriately defer to the agency entrusted by Congress to make such policy determinations." *Cooper Hosp.*, 179 F. Supp. 3d at 51 (citation omitted). That is to say, Section 1115 waivers generally are not susceptible to challenge on the basis that the Secretary has reversed positions because Section 1115 waivers are inherently fact bound. This is especially true here. The work programs that the prior administration declined to approve differ in meaningful respects from Kentucky HEALTH's community-engagement

initiative. For example, Arizona's proposed waiver required enrollees to be employed, actively seeking employment, or attending school or a job-training program. *See, e.g.*, A.R.S. § 36-2903.09(A)(1). New Hampshire's waiver proposal, which the prior administration rejected days before the 2016 presidential election, is similarly distinguishable. Among other things, New Hampshire's proposal required 30 hours per week of defined activities (as opposed to 80 hours per month).[8]

The Section 1115 waivers rejected by the prior administration differ from Kentucky HEALTH in one other significant respect: the population affected by the waiver. Perhaps more than any other state, Kentucky and its population are ideally situated to test a community-engagement program. As Governor Bevin explained in Kentucky's initial waiver submission, Kentucky's unique situation drove the need for a Section 1115 waiver:

> The need for change [in Kentucky] is urgent. Almost twenty percent of our residents live in poverty, we are 47th in the nation for median household income, nearly one-third of Kentuckians are on Medicaid, and our workforce participation is among the worst in the nation at less than 60 percent. Kentucky also ranks third in the nation for drug related fatalities.

(AR 5432.) These troubling statistics make Kentucky a particularly good fit for testing a community-engagement program. At a minimum, it is a reasonable construction of Section 1115 and a valid exercise of the Secretary's judgment to conclude that this is so.

Third, the prior administration did allow states to conduct voluntary work programs, albeit outside of Section 1115. For example, in 2014, the Secretary allowed Pennsylvania to pursue a

[8] New Hampshire Waiver Request, at 4–5 (Aug. 10, 2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-state-application-081016.pdf (last visited Feb. 4, 2019).

voluntary work program "outside the demonstration."[9] Similar programs followed in Indiana and Arkansas.[10] However, the available data from these voluntary work programs showed *exceptionally low participation rates*. For example, Indiana's results showed that:

> 244,000 HIP members were unemployed, while an additional 58,000 members were working fewer than 20 hours per week. Despite these numbers, with a voluntary Gateway to Work initiative, members are not properly incentivized to actively seek employment, resulting in only 580 Gateway to Work orientations being attended during the first fifteen (15) months of the program.[11]

Arkansas's voluntary work program was similarly ineffective from a participation perspective, with only 4.7 percent of beneficiaries referred to the work program following through and accessing the work-referral services.[12] CMS specifically relied on these anemic participation rates in its initial approval of Kentucky HEALTH's mandatory community-engagement initiative, reasoning that "[w]e understand from some states that these incentives have not been strong enough to influence individual beneficiary behavior. CMS and Kentucky believe that Kentucky HEALTH's community engagement initiative is likely to be more effective than other incentives or referrals to employment services, as it provides for the consequence of eligibility suspension for non-compliance." (AR at 4–5.) This sentiment was reiterated by CMS in its approval of

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[9] Pennsylvania Approval Letter & STCs, at 2 (Aug. 28, 2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-ca.pdf (last visited Feb. 4, 2019).

[10] Indiana Approval Letter & STCs, at 3 (Jan. 27, 2015), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appvl-01272015.pdf (last visited Apr. 21, 2018); Arkansas Approval Letter & STCs, at 4 (Mar. 5, 2018), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf (last visited Feb. 4, 2019).

[11] Indiana Amendment Request, at 7 (July 20, 2017), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-07202017.pdf (last visited Feb. 4, 2019).

[12] Arkansas Waiver Approval & STCs, at 4–5, *supra* note 14.

Kentucky HEALTH following this Court's remand. "To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence." (AR at 06731.) In sum, Kentucky HEALTH's community-engagement program is not a reversal in agency position so much as it is a natural and logical next step from voluntary work programs, which proved altogether ineffective at driving participation.

And fourth, not every change by an agency automatically renders deference to the Secretary's decision somehow inappropriate. *See Navarro*, 136 S. Ct. at 2125 (2016). Where, as here, the change in position did not upset long-settled expectations, "[a] summary discussion" of the change may suffice. *Id.* at 2126. To the extent that the waiver denials during the prior administration can be characterized as a reversal, the Secretary has given a reasoned explanation for the change. In its initial approval of Kentucky HEALTH, CMS recognized that it "has not previously approved a community engagement requirement as a condition of eligibility" and that "CMS has rejected similar proposals in the past." (AR at 4, 8.) In that initial approval letter, CMS offered several reasons for approving Kentucky HEALTH's community-engagement requirement, including (among others):

- "CMS has long supported policies that recognize meaningful work as essential to the economic self-sufficiency, self-esteem, well-being, and improved health of people with disabilities." (AR at 4.).
- Previous work-incentive programs, which were purely voluntary, "may not have been strong enough to influence individual beneficiary behavior." (AR at 4–5.).
- CMS concluded that Kentucky's community-engagement program responded to public commenters' concerns by including "important protections for vulnerable individuals." (AR at 8.).

Furthermore, the Secretary's approval following remand also provided additional justification supporting the community-engagement requirements.

- "Kentucky HEALTH…is also likely to promote the objective of helping beneficiaries attain or retain financial independence. The community engagement provisions generally require Kentucky HEALTH beneficiaries to work, look for work, or engage in activities that enhance their employability, such as job-skills training, education, and community service." (AR at 06724)

- "Where individuals among the Kentucky HEALTH groups are capable of satisfying the community engagement requirement, CMS believes that including these individuals advances the purposes of Medicaid by improving beneficiary health and independence and enhancing the program's fiscal sustainability." (AR at 06734)

This summary is more than sufficient for the Secretary's judgment to warrant deference. *See Navarro*, 136 S. Ct. at 2126 (holding that an agency must "display awareness that it is changing position" and "show that there are good reasons for the new policy" (citation omitted)).

CMS's January 11, 2018 letter to state Medicaid directors provides even further justification for the Secretary's position. The January 11, 2018 letter cites numerous studies that support the Secretary's decision. (AR at 91.) Furthermore, CMS' letter of November 20, 2018 approving Kentucky HEALTH following remand also cited numerous studies that reinforce the positive relationship between community engagement and wellness. (AR at 06733 fn. 9 and 10.) In its January 11, 2018 letter, CMS admitted that its willingness to approve programs like Kentucky HEALTH "is a shift from prior agency policy regarding work and other community engagement as a condition of Medicaid eligibility or coverage, but it is anchored in historic CMS principles that emphasize work to promote health and well-being." (AR at 92.) CMS further observed that it "has long assisted state efforts to promote work and community engagement and provide incentives to disabled beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work." (AR at 91.)

B. The Secretary validly approved Kentucky HEALTH's premiums.

Plaintiffs next challenge the Secretary's approval of premiums as part of Kentucky HEALTH. In so doing, Plaintiffs mischaracterize the applicable STCs. Pregnant women, survivors of domestic violence, former foster care youth, the medically frail and beneficiaries who are eligible for transitional medical assistance as described in sections 1925 and 1931(c)(2) of the Act are not required to pay premiums. (AR at 06769.) Non-exempt enrollees with incomes of greater than 100 percent of FPL are required to pay modest premiums of at least $1 per month but not to exceed 4 percent of household income. (AR at 06769.) For enrollees with incomes of less than 100 percent of FPL, they have the option of paying premiums to unlock the full benefits of Kentucky HEALTH. If they fail to pay these optional premiums, they are not dis-enrolled from Kentucky HEALTH; instead, they continue receiving all of its benefits except the optional benefits that come with the *My Rewards* account and must make copayments "equal to the copayments schedule in the Kentucky Medicaid state plan." (*Id.*) In addition to Kentucky HEALTH, the Secretary has approved some version of premiums under Section 1115 in Arizona, Arkansas, Indiana, Iowa, Michigan, and Montana. *See Musumeci, et al.*

Plaintiffs nevertheless allege that the Secretary has been wrong all along because Medicaid's limitation on premiums is not part of Section 1396a and thus cannot be waived under Section 1115. This could not be more wrong. Section 1396a(a)(14), which is part of Section 1396a, states that "[a] State plan for medical assistance must . . . provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title." Plaintiffs posit that Section 1396a(a)(14)'s language "only as provided in" conveys that the Secretary cannot waive the limitation on premiums. (ECF 91-1 at 51-52.) Section 1115, as written, allows the Secretary to waive "any" requirement of Section

1396a. The language "only as provided in" does not *sub silentio* overrule Section 1115's broad language. It simply directs the reader to the provision concerning premiums, if a waiver of Section 1396a(a)(14) has not been granted. To waive Section 1396a(a)(14), as the Secretary has done, logically means that a state can impose premiums without complying with Section 1396o. Not only is that a reasonable construction of Sections 1115 and 1396a(a)(14) sufficient to warrant deference, but it is the correct reading of the statutes: not having to comply with Section 1396o as it pertains to premiums necessarily follows from waiving Section 1396a(a)(14).

Plaintiffs resist this conclusion by pointing to Section 1396o-1, which they argue "also prohibits states from imposing premiums on enrollees with income below 150% of FPL" and which they note is not referenced in Section 1396a. (ECF 91-1 at 50-51.). Section 1396o-1 itself definitively refutes this argument. Section 1396o-1(b)(6)(B)—a provision that Plaintiffs fail to mention—states that "[n]othing in this section shall be construed . . . as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost-sharing under this section." Thus, section 1396o-1 unambiguously states that it does not limit the Secretary's waiver authority, which is exactly the purpose for which Plaintiffs are asking the Court to use it. The legislative history of Section 1396o-1 likewise conveys that it does not alter Section 1115. *See* Conf. Rep. No. 109-262, at 312 (2005) ("The bill further specifies that these provisions would not prevent states from further limiting cost-sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect waivers in effect before the date of enactment.").

Plaintiffs' argument about Section 1396o-1, if sustained, renders the Secretary's ability to waive Section 1396a(a)(14) meaningless with respect to premiums. According to Plaintiffs, Sections 1396o and 1396o-1 are redundant in prohibiting the Secretary from imposing premiums on anyone with an income below 150 percent of FPL. (ECF 91-1 at 50-51.) Plaintiffs' position,

then, is that in order for the Secretary to impose premiums, he must separately waive *both* overlapping provisions. This elevates form over substance. If the Secretary can waive Section 1396o's limitations on premiums, it cannot be the case that Section 1396o-1's overlapping provisions nonetheless stand in the way of the Secretary's waiver authority. Otherwise, Section 1115 would be meaningless with respect to Section 1396a(a)(14)'s limitation on premiums.

Plaintiffs also observe that Section 1396o has its own waiver provision in subsection (f), with the implication being that it supplants Section 1115. (ECF 91-1 at 51.) However, this limited waiver provision, by its terms, *does not apply to premiums*. It states: "No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary . . . unless [five requirements are met] . . . ." 42 U.S.C. § 1396o(f). As written, Section 1396o(f) in no way modifies the Secretary's Section 1115 waiver authority with respect to premiums. It applies to a "deduction, cost sharing, or similar change" and nothing else. Moreover, Section 1396o(f) does not state, or even imply, that the Secretary can only waive requirements of Section 1396o through Section 1396o(f). To the contrary, by using the language "under any waiver authority of the Secretary," Section 1396o(f) expressly recognizes that the Secretary has waiver authorities other than Section 1396o(f) *that continue to exist*, and it modifies those other authorities *only as to* a waiver of a "deduction, cost sharing, or similar charge." To conclude otherwise would be to find that the Secretary's ability to waive Section 1396a(a)(14) under Section 1115 is all but meaningless—that is, the Secretary technically can waive Section 1396a(a)(14) under Section 1115, but in actuality he cannot waive premium limitations at all and he can only waive cost-sharing restrictions consistent with Section 1396o(f).

Next, Plaintiffs rely on *Pharmaceutical Research & Manufacturers of America v. Thompson*, 251 F.3d 219 (D.C. Cir. 2001), which stated in *dicta* that Section 1115 "does not

authorize [the Secretary] to waive . . . the requirement that Medicaid beneficiaries contribute no more than a 'nominal' amount to the cost of medical benefits they receive." *Id.* at 222. It must be noted that this aspect of Thompson's decision was *dicta* because the Court specifically declined to consider the underlying alternative argument. *Id*. at 226.

Regardless, Plaintiffs read this to hold broadly that "Section 1115 does not authorize the Secretary to waive the premium and cost sharing limits." (ECF 91-1 at 50.) Plaintiffs are wrong. *Thompson*'s *dicta* was carefully limited to the Secretary's inability under Section 1115 to waive the requirement that beneficiaries only contribute a "nominal" amount toward their medical benefits. That requirement comes from Section 1396o(a)(3), which states that "any deduction, cost sharing, or similar charge imposed under the plan . . . will be nominal in amount . . . ." Section 1396o(a)(3) does not apply to premiums—only to "any deduction, cost sharing, or similar charge." Although *Thompson* did not say so, its *dicta* was grounded in Section 1396o(f), which as discussed above provides a separate waiver authority for a "deduction, cost sharing, or similar charge."

Plaintiffs also claim that how the Medicaid Act has been amended over time, allegedly in response to two district court decisions, demonstrates that Congress intended to make it impossible for the Secretary to waive Medicaid's limit on premiums. (ECF 91-1 at 52.) Both cited district court decisions dealt with cost sharing, not premiums. *Crane*, 417 F. Supp. at 537; *Richardson*, 348 F. Supp. at 493–95. This simple fact eviscerates Plaintiffs' favored narrative. In addition, the excerpted legislative history on which Plaintiffs rely says nothing about limiting the Secretary's ability to waive the limitation on premiums (as opposed to limiting his ability to waive restrictions on cost sharing). *See* S. Rep. 97-757, at 6 (1982) ("The Committee notes that a large number of States have sought waivers of current law relating *to the imposition of cost-sharing* under the demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the

States sufficient flexibility *in this regard* to make further exercise of the Secretary's demonstration authority unnecessary." (emphases added)).

C The Secretary had authority to approve Kentucky HEALTH's provisions regarding non-emergency use of the emergency room.

Plaintiffs next challenge Kentucky HEALTH's method of incentivizing enrollees not to use the emergency room for non-emergency treatment. Federal law already allows hospitals to require Medicaid enrollees to pay modest amounts each time they engage in this inefficient behavior. *See* 42 U.S.C. § 1396o-1(e). However, in 2015, nearly 125,000 Medicaid enrollees in Kentucky went to the emergency room for a non-emergent condition. (AR at 5463.)

Kentucky HEALTH links non-emergency use of the emergency room to an enrollee's *My Rewards* account, which an enrollee can use for enhanced benefits, like paying for dental and eye care. (AR at 06763-06766.) An enrollee's *My Rewards* account accumulates virtual dollars when the enrollee engages in healthy behavior. (AR. 5461–63.) However, the opposite also is true: When an enrollee uses the emergency room for non-emergency treatment, his or her *My Rewards* account decreases—by $20 for the first visit, $50 for the second visit, and $75 for every visit thereafter. (AR. at 5463.) To be clear, the *My Rewards* account is not comprised of actual money. In reality, the virtual dollars in a *My Rewards* account are the equivalent of points that fluctuate up and down. Kentucky HEALTH chooses to express those points as virtual dollars to approximate for enrollees a commercial insurance experience. (AR at 06271 and 06724.)

Plaintiffs claim that this incentive structure violates Medicaid's restrictions on cost sharing, which the Secretary did not waive with respect to Kentucky HEALTH. But decreasing the virtual dollars in an enrollee's *My Rewards* account is not cost sharing. At a minimum, it is a reasonable construction of Section 1396o to reach this conclusion. For one thing, enrollees do not contribute money to their *My Rewards* accounts, such that it is deducted from them when they receive non-

emergency treatment at an emergency room. And if Plaintiffs lose coverage, they cannot take their *My Rewards* balances with them. (*See* AR at 06763 and 5463.) Plaintiffs nevertheless ask the Court to collapse the differences between taking money out of an enrollee's pocket—cost sharing—and reducing the amount of virtual money available in an enrollee's *My Rewards* account. As justification, Plaintiffs cite the definition of cost sharing as "any deduction, copayment, or similar charge," 42 U.S.C. § 1396o-1(a)(3)(B), and urge that a reduction in a *My Rewards* account is either a "deduction" or a "similar charge."

However, analyzing Sections 1396o and 1396o-1 as a whole, it is unmistakable that cost sharing means amounts that an enrollee directly pays. *See Rehab. Ass'n of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1454 (4th Cir. 1994) ("Without getting into much detail, 42 U.S.C. § 1396o relates to a state's ability to *impose certain charges on certain plan participants* for certain services." (emphasis added)). For example, Section 1396o(e) states:

> The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's *inability to pay* a deduction, cost sharing, or similar charge. The requirements of this subsection *shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.*

Id. (emphases added). The italicized portions of Section 1396o(e) establish that a "deduction, cost sharing, or similar charge" is something that an enrollee directly pays as opposed to something that is taken from a *My Rewards* account for which the enrollee did not pay in the first instance. Section 1396o-1(d)(2) likewise envisions "*the payment* of any cost sharing authorized to be imposed under this section with respect to such care, items, or services." *Id.* (emphasis added). In sum, when Sections 1396o and 1396o-1 talk about cost sharing, they refer to making the enrollee actually pay money to someone else, which is distinguishable from reducing virtual dollars in a *My Rewards* account.

In fact, Kentucky HEALTH itself distinguishes between cost sharing and reducing the amount in an enrollee's *My Rewards* account. More specifically, Kentucky HEALTH permits an enrollee to carry a negative balance in his or her *My Rewards* account. (AR at 06764-06765.) However, even if an enrollee's *My Rewards* account has a negative balance, the enrollee is not required to reimburse the deficit. (AR at 06765; *see also* AR at 5463.)

CONCLUSION

The Court should grant the Commonwealth's motion for summary judgment and deny Plaintiffs' motion.

Respectfully submitted,

/s/ M. Stephen Pitt
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S. Chad Meredith
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Counsel for the Commonwealth of Kentucky

CERTIFICATE OF SERVICE

I certify that on January 4th, 2019 I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic copy to counsel of record.

/s/ M. Stephen Pitt
Counsel for the Commonwealth of Kentucky

EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 1:18-cv-152 (JEB)
	)	
ALEX M. AZAR II, *et al.*,	)	
	)	
Defendants.	)	

AFFIDAVIT OF STEPHAN R. BECHTEL

Affiant, being duly sworn, states as follows:

1. The affiant's name is Stephan R. Bechtel. I am the Chief Financial Officer for the Department for Medicaid Services, which is within the Kentucky Cabinet for Health and Family Services.
2. The Department for Medicaid Services administers Kentucky's Medicaid program.
3. The assertions made herein are within my scope of my employment and within my personal knowledge.
4. On December 17, 2017, the enrollment for the Medicaid expansion population in Kentucky was 490,668. On December 17, 2018, the enrollment for the Medicaid expansion population in Kentucky was 450,008.
5. On December 17, 2017, the enrollment for the non-expansion population in Kentucky ("traditional Medicaid") was 862,203. On December 17, 2018, the enrollment for the non-expansion population in Kentucky was 842,595.

Further affiant sayeth naught.

STEPHAN R. BECHTEL

COMMONWEALTH OF KENTUCKY)
) ss.
COUNTY OF FRANKLIN)

Subscribed and sworn to before me by Stephan R. Bechtel, Affiant, on this the 1 day of February, 2019.

Notary Public

My commission expires: June, 2019

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 1:18-cv-152 (JEB)
	)	
	)	
ALEX M. AZAR II, *et al.*,	)	
	)	
Defendants.	)	

[PROPOSED] ORDER

This matter is before the Court on the motion of the Commonwealth of Kentucky, through Governor Matthew G. Bevin, for summary judgment and the motion of Plaintiffs for summary judgment. The Court GRANTS Kentucky's motion for summary judgment and DENIES Plaintiffs' motion for summary judgment. Plaintiffs' claims are DISMISSED WITH PREJUDICE.

SO ORDERED this_____day of_____, 2019.

_____
HON. JAMES E. BOASBERG
UNITED STATES DISTRICT JUDGE