**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| MONTE A. ROSE, JR., *et al.*, | ) | |
| | ) | |
| Plaintiffs. | ) | |
| | ) | |
| v. | ) | |
| | ) | No. 1:19-cv-02848-JEB |
| XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services, *et al.*, | ) | |
| | ) | |
| Defendants. | ) | |
| | ) | |

**PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

For the reasons set forth in the accompanying memorandum of law, Plaintiffs respectfully request that this Court grant summary judgment on their claims that federal Defendants' October 26, 2020 and December 22, 2023 approvals of the Healthy Indiana Plan project violate the Administrative Procedure Act and the Social Security Act. *See* Fed. R. Civ. P. 56.

Dated: March 20, 2024

Respectfully submitted,

/s/ Ian Heath Gershengorn
Ian Heath Gershengorn
Thomas J. Perrelli
Erica S. Turret
JENNER & BLOCK
1099 New York Ave., Suite 900
Washington, DC 20001
(202) 639-6869
Igershengorn@jenner.com
Eturret@jenner.com

*Counsel to National Health Law Program*

/s/ Jane Perkins
Jane Perkins
Catherine McKee
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
(919) 968-6308 (x101)
perkins@healthlaw.org
mckee@healthlaw.org

Adam Mueller
INDIANA JUSTICE PROJECT
1100 W 42nd St. Suite 200
Indianapolis, IN 46208
(317) 912-1135 ext. 800
amueller@injp.org

*Counsel for Plaintiffs*

**CERTIFICATE OF SERVICE**

I hereby certify that on March 20, 2024, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to all authorized CM/ECF filers.

By: /s/ Ian Heath Gershengorn
Ian Heath Gershengorn

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**PLAINTIFFS' MEMORANDUM IN SUPPORT OF**
**MOTION FOR SUMMARY JUDGMENT**

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## INTRODUCTION

Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive mandatory Medicaid provisions so that a state can carry out an experimental project that is likely to promote the objectives of the Medicaid Act. 42 U.S.C. § 1315. Section 1115 "was not enacted to enable states to save money or evade federal requirements." *Stewart v. Azar*, 366 F. Supp. 3d 125, 150 (D.D.C. 2019) (cleaned up) (*Stewart II*). A Section 1115 project can last only for the period necessary for the state to conduct its experiment.

Invoking Section 1115, the Secretary first approved the Healthy Indiana Plan (HIP) in 2008. As approved, the project offered Medicaid coverage to individuals who, at the time, were not otherwise eligible through the Medicaid Act. HIP was designed to resemble a commercial, high-deductible health plan and "test a model of health coverage that emphasizes private health insurance, personal responsibility, and 'ownership' of health care." Letter from Kerry Weems, Acting Adm'r., CMS, to E. Mitchell Roob, Jr., Sec'y, Ind. Fam. & Soc. Servs. Admin. at 1-2 (Dec. 14, 2007) ("2007 Approval Letter"), Ex. A to ECF No. 50-1. The Secretary allowed Indiana to restrict coverage by charging monthly premiums (and terminating coverage for failure to pay), imposing lockout penalties, and eliminating three-months' retroactive eligibility and coverage of non-emergency medical transportation (NEMT). The Secretary renewed HIP repeatedly, permitting Indiana to maintain these core features even as the population included in the project became eligible for coverage through the Medicaid Act. In October 2020, the Secretary extended the project for an unprecedented 10 years.

"The issues presented in this case are all too familiar." *Philbrick v. Azar*, 397 F. Supp.3d 11, 15 (D.D.C. 2019), *aff'd*, No. 19-5293, 2020 WL 2621222 (D.C. Cir. May 20, 2020), *vacated sub nom. Becerra v. Gresham*, 142 S. Ct. 1665 (2022). As was the case with other states' projects,

the Secretary justified the extension of the 2020 Indiana project on the basis that it would "facilitate transition of enrollees to commercial coverage," "improve health," "promote financial independence," and ensure the "fiscal sustainability of the safety net." He did not adequately consider the likely effects of the project on the primary purpose of the Medicaid Act—providing health care coverage. This, despite the fact that the Court has repeatedly reminded the Secretary of his obligation to do so. *See Stewart II,* 366 F. Supp. 3d at 139; *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (*Stewart I*); *Philbrick*, 397 F. Supp. 3d at 23. Adding to this critical error, the Secretary failed to explain how HIP could possibly remain experimental nearly 13 years after its implementation or why approving the project for another decade was permissible or necessary.

In December 2023, the Secretary doubled down, reaffirming the 2020 extension. The letter announcing the decision was wholly illogical, spending eight pages discussing the extensive evidence showing that premiums cause coverage loss, but allowing the project to proceed on the grounds that stopping it could cause administrative disruption for the State. Equally confounding, the Secretary issued the decision soon after having denied several other states' requests to continue imposing premiums through Section 1115, citing much of the same evidence and concluding that premiums are not likely to promote the objectives of the Medicaid Act.

The HIP extension has harmed and will continue to harm Plaintiffs and other low-income individuals who need health care, including primary care, blood work and other diagnostic testing, vision and dental care, and treatment for Long COVID and cardiac concerns. Without access to Medicaid, people forgo needed care or incur medical bills when they seek treatment. In approving the 2020 HIP extension and reapproving it in December 2023, the Secretary exceeded his statutory authority and failed to engage in reasoned decision-making. The approvals violated the Administrative Procedure Act (APA) and the Social Security Act and should be vacated.

## STANDARD OF REVIEW

The APA is the principal safeguard against irrational, incoherent, or unexplained agency decision making. Under the APA standard of review, *see* 5 U.S.C. § 706, the court must ensure that agency action constitutes "reasoned decisionmaking." *Stewart I.*, 313 F. Supp. 3d at 259 (quoting *Michigan v. EPA*, 576 U.S. 743, 750 (2015)). The agency must "examine all relevant factors and record evidence," *American Wild Horse Preservation Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017), weigh "reasonably obvious alternative[s]" to its chosen course, *Walter O. Boswell Memorial Hospital v. Heckler*, 749 F.2d 788, 797 (D.C. Cir. 1984) (citation omitted), and furnish "a satisfactory explanation for its action"—one that draws a "rational connection between the facts found and the choice made. . . ." *Stewart II*, 366 F. Supp. 3d at 135 (quoting *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983)) (internal quotation marks omitted); *Multicultural Media, Telecom. & Internet Council v. FCC*, 873 F.3d 932, 937 (D.C. Cir. 2017) (agency's decision "must be both reasonable and reasonably explained"). Courts "do not defer to the agency's conclusory or unsupported suppositions," *Stewart II,* 366 F. Supp. 3d at 135 (quoting *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557, 562 (D.C. Cir. 2010)), and merely "[s]tating that a factor was considered . . . is not a substitute for considering it," *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986).

"Summary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [APA] standard of review." *Stewart I*, 313 F. Supp. 3d at 249 (cleaned up).

## STATEMENT OF FACTS

### I. The Federal Medicaid Program

Title XIX of the Social Security Act establishes Medicaid. *See* 42 U.S.C. §§ 1396-1396w-7. Congress enacted Medicaid "[f]or the purpose of enabling each State, as far as practicable . . . to furnish (1) medical assistance" on behalf of families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id.* § 1396-1.

States do not have to participate in Medicaid, but all do. To receive federal funding, a state must implement Medicaid consistent with a state plan approved by the Secretary. *Id*. § 1396a. The plan must describe the state's program and affirm its commitment to comply with the Medicaid Act and implementing regulations. *Id*. §§ 1396a, 1316(a)(1); 42 C.F.R. § 430.10. The federal government reimburses states for a portion of "the total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1), (b).

The Medicaid Act describes the population groups that are eligible to receive medical assistance. *Id.* § 1396a(a)(10)(A), (C). States must cover individuals described in Section 1396a(a)(10)(A)(i) (the "mandatory categorically needy") and may cover individuals described in Sections 1396a(a)(10)(A)(ii) (the "optional categorically needy") and 1396a(a)(10)(C) (the "medically needy"). States may not impose eligibility requirements that are not explicitly allowed. *Id*. § 1396a(a)(10)(A); *see, e.g.*, *Jones v. T.H.*, 425 U.S. 986 (1976) (affirming ruling that Utah regulation violated Title XIX by adding requirement for obtaining medical assistance).

Prior to the Affordable Care Act (ACA), covered population groups included children, pregnant women, parents and caretaker relatives, and individuals who were aged, blind, or

disabled. The ACA added another mandatory group—adults who are under age 65, not otherwise eligible for Medicaid or Medicare, and have household incomes below 133% of the federal poverty level (FPL) (the "expansion population"). *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). The Supreme Court subsequently prohibited the Secretary from terminating federal funding to states that do not take up the Medicaid expansion, *National Federation of Independent Business (NFIB) v. Sebelius*, 567 U.S. 519, 585 (2012); however, the expansion population continues to be a mandatory coverage group in the Medicaid Act itself. The majority of states, including Indiana, have approved state plans to cover the expansion population. *See* Kaiser Fam. Found., *Status of State Medicaid Expansion Decisions: Interactive Map* (Feb. 7, 2024), https://bit.ly/4a9ejK3.

Medical assistance includes a broad array of institutional and community-based services, *see* 42 U.S.C. § 1396d(a), including NEMT, *id.* §§ 1396a(a)(4)(A), 1396d(a)(31); 42 C.F.R. §§ 431.53, 440.170. Medical assistance must extend to the three months before an individual's application if the individual would have been eligible for medical assistance at the time the care was received. 42 U.S.C. §§ 1396a(a)(34), 1396a(a)(10)(A), 1396d(a).

## II. Section 1115 of the Social Security Act

Section 1115 of the Social Security Act gives the Secretary limited authority to "waive compliance" with Medicaid Act requirements. *Id.* § 1315(a)(1). The Secretary can only approve an "experimental, pilot, or demonstration" project that is "likely to assist in promoting the objectives" of the Medicaid Act. *Id.* § 1315(a); *see* S. Rep. No. 87-1589, at 19-20 (1962) *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (stating congressional intent that projects "test out new ideas and ways of dealing with the problems of public welfare recipients," "be selectively approved," and "designed to improve the techniques of administering assistance

and . . . related rehabilitative services"). "Once the Secretary has greenlighted such a project, he can then waive compliance with the requirements of Section 1396a 'to the extent and for the period . . . necessary'" to enable the state to carry out its experiment. *Stewart I*, 313 F. Supp. 3d at 245; *see id*. at 254. The costs of the approved project are regarded as expenditures under the state plan. 42 U.S.C. § 1315(a)(2).

Section 1115 does not authorize waivers in perpetuity. Congress has established outer limits for the duration of statewide, comprehensive demonstration projects, allowing only two extensions of up to three years each (or up to five years each for projects involving dual eligibles, individuals eligible for both Medicare and Medicaid). *See id*. § 1315(e)(2), (f)(6). Despite these limits and the requirement that a project be experimental, in 2017, CMS issued a Bulletin announcing its intent to "[w]here possible . . . approve the extension of *routine, successful, non-complex*" Section 1115(a) waivers for a period of up to ten years. CMS, CMCS Informational Bulletin: Section 1115 Demonstration Process Improvements 3 (Nov. 6, 2017), https://bit.ly/3vauRCM (emphasis added) ("2017 Informational Bulletin"). CMS did not explain how this new policy would comply with Section 1115.

## III. The Healthy Indiana Plan

In 2007, Indiana passed legislation to extend Medicaid coverage to certain low-income adults who, at the time, were not otherwise eligible for coverage under the Medicaid Act. 2007 Ind. Acts 3525. To implement the legislation, Indiana applied for a Section 1115 project called the Healthy Indiana Plan (HIP). The Secretary, acting through the Centers for Medicare & Medicaid Services (CMS), approved the project, effective January 1, 2008 through December 31, 2012. 2007 Approval Letter.

Indiana designed HIP to resemble a commercial, high-deductible health insurance plan and "test a model of health coverage that emphasizes private health insurance, personal responsibility, and 'ownership' of health care." *Id*. at 1-2. To this end, the Secretary permitted Indiana to impose restrictions on coverage, including mandatory monthly premiums and loss of coverage for failure to pay, lockout penalties for failing to pay premiums or meet eligibility redetermination deadlines, and the elimination of retroactive eligibility and NEMT. CMS, Special Terms and Conditions HIP (2007) 20-21, 25-26, 47-48 ("2007 STCs"), Ex. B. to ECF No. 50-1. Enrollees paid premiums into a Personal Wellness and Responsibility (POWER) account and used the account to pay for health care until they reached their deductible. *Id*. at 10. Enrollees with money in the account at the end of their eligibility period could roll the balance into the next year to reduce their premiums. *Id*. at 24. However, enrollees who did not receive all recommended preventive services during the eligibility period could only roll over amounts that they—not the State—paid into the account. *Id*.

Between 2012 and 2015, CMS approved several short-term extensions of HIP while it negotiated with Indiana regarding coverage of the expansion population. Effective February 1, 2015, Indiana amended its state plan to include the expansion population. State Plan Amendment IN-15-0001-MM1, https://bit.ly/4ca4Ofv. Effective that same day, CMS extended HIP, now labelled HIP 2.0, through December 31, 2018. Letter from Marilyn Tavenner, Adm'r. CMS, to Joseph Moser, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (Jan. 27, 2015) ; CMS, Waiver List for HIP 2.0 (2015); CMS, Special Terms and Conditions HIP 2.0 (2015) ("2015 STCs"), https://bit.ly/49LTW67. In addition to extending the existing project, the approval allowed Indiana to offer different benefit packages to the expansion population, HIP Basic and HIP Plus, with HIP Plus covering all HIP Basic services plus vision and dental care. 2015 STCs at 14. With the

exception of medically frail individuals, enrollees with incomes at or below the FPL who did not pay their monthly premiums received HIP Basic. *Id*.

In January 2017, Indiana applied to the Secretary to extend HIP 2.0. Letter from Gov. Eric J. Holcomb to Norris Cochran, Acting Sec'y, Dep't of Health & Hum. Servs. (Jan. 31, 2017), https://bit.ly/3v7QYcP. Indiana reiterated the purpose of the project was to "align with standard commercial market policies to educate members and prepare them" to use private insurance coverage, stating that HIP 2.0 "empower[s] enrollees to become active consumers of healthcare services," and the premiums "give[] participants 'skin-in-the-game'" Ind. Fam. & Soc. Servs. Admin., *Healthy Indiana Plan: Section 1115 Waiver Extension Application* 4 (Jan. 31, 2017), https://bit.ly/3v7QYcP. In the package, Indiana proposed to add a program for individuals with substance use disorder (SUD), which would allow the State to receive federal funding for services provided in institutions for mental diseases, which are ordinarily stated funded. *Id*. at 33-37. While the extension request was pending, Indiana asked the Secretary to add work requirements as a condition of eligibility. Ind. Fam. & Soc. Servs. Admin., *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application* (July 20, 2017), https://bit.ly/3wZ3Wu6.

CMS approved the package through December 31, 2020. Letter from Demetrios L. Kouzoukas, Principal Deputy Adm'r., CMS, to Allison Taylor, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (Feb. 1, 2018) ("2018 Approval Letter"); CMS, HIP Special Terms and Conditions (2018) ("2018 STCs"), https://bit.ly/4cpWGre. As approved, the objectives of the project were to "improve health outcomes, promote increased upward mobility and improve quality of life, increase individual engagement in health care decisions, and prepare individuals who transition to commercial health insurance coverage to be successful in this transition." 2018 Approval Letter at 6; *see*, *e.g.*, *id*. at 10, 18 (describing purpose of premiums as to help "prepare beneficiaries for their

transition from Medicaid into a commercial health insurance plan" and "improve beneficiary health and wellness"). The approval also authorized the SUD program. 2018 STCs at 29-37.

On September 23, 2019, Plaintiffs filed their Complaint challenging the HIP 2.0 extension. Compl., ECF No. 1. Indiana paused implementation of the work requirements as a result of the case. News Release, Ind. Fam. & Soc. Servs. Admin., *Pending Resolution of Federal Lawsuit, FSSA Will Temporarily Suspend Gateway to Work Reporting Requirement* (Oct. 31, 2019), https://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf.

Over the last 15 years, outside evaluators have conducted multiple evaluations of the HIP project, *see, e.g.*, Lewin Grp., *Indiana HIP 2.0 Interim Evaluation Report* (2016), https://bit.ly/49Pa1HU, AR 5955-6026, 6027-93, 4602-4930, finding, for example, that the premiums cause many people to lose Medicaid coverage, AR 5959, 5670-74, 4764.

**A. The 2020 Extension and Amendment of HIP**

With the 2020 approval end date approaching, Indiana asked CMS to extend HIP "with no substantive changes." AR 8238. Indiana sought the extension "[b]ased on the long-tenure and demonstrated success of HIP," *id*., stating that shorter approval periods "create[] unnecessary administrative burdens for the State and federal government, and do[] not meaningfully enhance the oversight or transparency of the demonstration," AR 8239; *see* AR 8263-65 (citing 2017 Informational Bulletin). In a separate document, Indiana requested a five-year extension of the SUD program. AR 8288-8315.

When the COVID pandemic hit, all states received enhanced federal funding to stop terminating Medicaid coverage, and Indiana suspended all premium and lockout penalties. Gov. Eric Holcomb, Exec. Order No. 20-05 (Mar. 19, 2020), https://www.in.gov/gov/files/EO_20-05.pdf. The Court granted Indiana's request to stay the case. Min. Order (Apr. 6, 2020).

On October 26, 2020, the Secretary approved the HIP extension application. AR 1554-1752. The extension applies to the same population groups and includes the same key features as the 2018 extension. However, the Secretary only approved the work requirements and the lockout penalties on the condition that the Supreme Court issue a decision in *Gresham v. Azar* "that legally authorize[d] these elements." AR 1554, 1576. The Secretary approved the remaining features of HIP for a 10-year period (and the SUD/SMI program for 5 years). AR 1555, 1575-78. In deciding the length of the HIP approval period, CMS considered: (1) Indiana's request; (2) whether "the authorities . . . had been previously or currently implemented over a sufficient period of time to support" a 10-year extension; and (3) "the importance, performance, and potential effectiveness" of the components. AR 1557-58. The approval letter did not explain how the HIP extension was consistent with the CMS policy announced in the 2017 Informational Bulletin. The Secretary concluded that the project would promote the objectives of Medicaid by improving the sustainability of the safety net, which could ultimately promote coverage, increase beneficiaries' financial independence, and help them transition successfully to commercial health insurance, and improve beneficiaries' health outcomes. AR 1554-74.

In early 2021, CMS notified Indiana that it had "preliminarily determined" that work requirements "would not promote the objectives of the Medicaid program" and that it was deciding whether to withdraw its conditional approval of the requirements. AR 1075-77. CMS told the State it was reviewing its approval of the other HIP waiver authorities as well. AR 1076.

In June of 2021, CMS withdrew conditional approval of the work requirements, concluding that they are not likely to promote the objectives of the Medicaid Act. AR 0838-61. CMS reiterated that its re-assessment of the other waiver authorities approved in 2020 was ongoing. AR 0860. The Supreme Court did not issue a decision in *Gresham* that legally authorizes work requirements or

lockout penalties. *See Becerra v. Gresham*, 142 S. Ct. 1665 (2022) (vacating D.C. Circuit opinion and remanding with instructions to the district court to vacate its judgment and dismiss the case as moot). As a result of these developments, the work requirements and lockout penalties are no longer a part of the approved HIP project. The key features of the HIP project that remain in place are described below.

**Monthly Premiums and Penalties for Failure to Pay.** With the exception of pregnant women, Indiana continues to charge individuals at all income levels monthly premiums (from $1-$20 per month depending on income). AR 1598-1601, 0002. Beginning in their second year of enrollment in HIP, individuals who use tobacco are charged an additional 50% on their premiums. AR 1601-02. Indiana can change premium amounts annually without requesting an amendment, so long as the premiums do not exceed 3% of household income. AR 1559, 1602.

In general, HIP enrollees subject to the premium requirement do not receive Medicaid coverage until the first day of the month in which they pay the initial premium. AR 1589. Individuals with incomes above the FPL who do not pay their initial premium on time are not enrolled in Medicaid. AR 1589. Those who enroll, but do not pay a subsequent premium, are terminated from Medicaid unless they are determined medically frail. AR 1602-03. Individuals with incomes at or below the FPL who do not pay an initial or subsequent premium are subject to cost sharing at the point of service. AR 1598-99. And, if they are not determined medically frail, they are moved to HIP Basic and lose coverage of vision, dental, and chiropractic services. AR 1591, 1598, 1603 (allowing premiums and cost sharing up to 5% of household income per quarter).

According to the approval, the premiums were "designed to improve beneficiary health and wellness by encouraging beneficiaries to take ownership of decisions about health care options," AR 1563 and "provide beneficiaries the tools to successfully utilize commercial market

health insurance, AR 1565. At the time of the extension, the premium requirements had been authorized in Indiana pursuant to Section 1115 for nearly 13 years. The State plans to reinstate premiums in July 2024, *see* Joint Status Rpt. ¶10 (Jan. 12, 2024), ECF No. 49, and begin terminations for nonpayment in October 2024. *See* Medicaid Coverage Protections Q&A's (Mar. 7, 2024), https://bit.ly/3v95tNx.

**No Retroactive Coverage.** With the exception of pregnant women, HIP enrollees cannot receive the three months' retroactive coverage required by the Medicaid Act. AR 1577. According to the Secretary, the waiver of retroactive coverage is expected to improve beneficiary health by "improving uptake of preventive services," and to encourage individuals "to obtain and maintain health coverage, even when healthy. . . ." AR 1564; *see also* AR 1558. At the time of the 2020 extension, waiver of retroactive coverage had been authorized pursuant to Section 1115 for nearly 13 years.

**Elimination of NEMT.** With the exception of medically frail individuals, HIP enrollees in the expansion population do not receive NEMT. AR 1576. The Secretary stated that the purpose of the NEMT waiver is to enable Indiana to "better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health coverage, thus improving the fiscal sustainability of the Medicaid program." AR 1561-62. At the time of the 2020 extension, the elimination of NEMT had been authorized pursuant to Section 1115 for nearly 13 years.

### B. The December 2023 Decision to Allow HIP to Proceed

As noted, in 2021, the Secretary had informed the State that it was reassessing approval of the 2020 HIP extension. The completion of that review was announced in a December 22, 2023 decision letter that maintained the 10-year approval. AR 0001-11 ("December 2023 Letter").

The Secretary based the decision on the contention that withdrawal could be disruptive for the State as it prioritizes efforts to unwind Medicaid eligibility for enrollees who kept Medicaid coverage during the COVID public health emergency. AR 0001-02. At the time of the decision, Indiana was 8 months into a 12-month unwinding process, which had started in April 2023. *See* Ind. Fam. & Soc. Servs. Admin., *How a Return to Normal Will Impact Some Indiana Medicaid Members*, https://www.in.gov/medicaid/members/member-resources/How-a-return-to-normal-will-impact-some-Indiana-Medicaid-members/ (last visited Mar. 14, 2024). Premiums had not been imposed for nearly four years. *See* Gov. Eric Holcomb, Exec. Order No. 20-05 (Mar. 19, 2020), https://www.in.gov/gov/files/EO_20-05.pdf.

The December 2023 Letter cited extensive evidence showing that "premiums beyond those authorized under the Medicaid statute may reduce access to coverage and care among populations that Medicaid is designed to serve." AR 0004-11. Most of this evidence pre-dates the 2020 HIP extension. *See id*. The Secretary stated he is not aware of evidence indicating that charging beneficiaries premiums beyond those authorized in the Medicaid Act "facilitates coverage directly or indirectly." AR 0010. He allowed the State to maintain the waivers of retroactive coverage and NEMT and the 10-year length of the approval without any discussion. *See* AR 0001-11.

The extension of HIP is of grave concern to Plaintiffs, who are required to pay monthly premiums and are at risk of losing Medicaid coverage (in whole or in part) when they cannot pay. Plaintiffs anticipate that, as before when they had no health insurance, they will incur medical bills they cannot pay and will be forced to forgo needed care or depend on relatives and friends to help them. *See* Monte Rose, Jr. Decl. (March 15, 2024) (Ex. A hereto); Chelsey Lang Decl. (March 18, 2024) (Ex. B hereto); Emily Rames Decl. (March 13, 2024) (Ex. C hereto).

## ARGUMENT

### I. The Secretary's October 2020 Decision to Extend the HIP Project Violates the Administrative Procedure Act.

#### A. The HIP Project Does Not Include the Conditionally Approved Features or the SUD/SMI Program.

In reviewing a proposed Section 1115 project, the Secretary considers the project as a whole. *Stewart I*, 313 F. Supp. 3d at 253; *see id*. at 257 (noting the relevance of the project components in that review). In 2020, the Secretary allowed Indiana to continue implementing numerous policies—work requirements, premiums, lockout penalties, the SUD/SMI program, and the elimination of retroactive coverage and NEMT. However, for purposes of the Court's review, not all of these features are part of the HIP project.

To begin with, the Secretary only conditionally approved work requirements and lockout penalties. He intended for HIP to proceed without those elements unless and until the Supreme Court issued a decision in *Gresham* that "legally authorize[d]" them. AR 1554-55, 1559. As a result, the Secretary had the obligation to determine whether HIP met the requirements of Section 1115 without the conditionally authorized features. The work requirements and lockout penalties are no longer approved components of the project.

In addition, while the approval addresses the SUD/SMI program, the program is "wholly distinct from" the other components of the approval. *Stewart I*, 313 F. Supp. 3d at 258. The SUD/SMI program extends to a range of Medicaid beneficiaries, while the remainder of the approval applies only to adults who do not have a disability and are not elderly. *See id.*; AR 1587-90. The SUD/SMI program is approved through 2025, while the components of the HIP project, which have been in place since 2008, are approved through 2030. AR 1555. *See Stewart I*, 313 F. Supp. 3d at 258 (noting the different start dates for the SUD program and the other components).

The SUD/SMI program and the remainder of the HIP approval have different purposes. The SUD/SMI program is designed to improve access to high quality care for beneficiaries with SUD or SMI, reduce their use of emergency and inpatient hospital settings, and "combat prescription drug abuse and opioid use disorders." AR 1560-61. By contrast, HIP's foundational purpose is to prepare beneficiaries "for the personal responsibility required to maintain coverage and continuity of care" in commercial plans. AR 1557.

Both the Secretary and the State have treated the SUD/SMI program and HIP as distinct projects. In its 2020 renewal application, Indiana submitted one document requesting renewal of HIP and another requesting renewal of the SUD/SMI program. *See* AR 8235-87, 8288-8315; *see* AR 8234 (letter from Governor Holcomb to HHS noting that "[i]n addition to authorizing HIP, the existing waiver includes authority to operate a Substance Use Disorder (SUD) demonstration"). Similarly, the Secretary required Indiana to submit a separate implementation plan, monitoring protocol, mid-point assessment, and evaluation for the SUD/SMI programs and another for the other components of HIP. AR 1613-16, 1618-24; *Healthy Indiana Plan, Supporting Documents, Administrative Record,* https://bit.ly/49QYcRN (last visited Feb. 28, 2004); *see Stewart I*, 313 F. Supp. 3d at 258 (noting the Secretary "has solicited and regularly approved stand-alone SUD demonstrations in other states"). Tellingly, CMS did not mention the SUD/SMI program in its December 2023 letter announcing the result of its review of "authorities approved in the HIP demonstration." AR 0001. For these reasons, it is appropriate for the Court to treat the remaining elements of HIP, other than the SUD/SMI program, as the HIP project.

### B. The Secretary Promoted His Own Agenda at the Expense of the Objectives of the Medicaid Act.

Section 1115 only authorizes experiments that are "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). The Court has previously held that Section

1396-1 "provides a central objective of the Medicaid Act: to furnish medical assistance to the populations covered by the Act." *Stewart II*, 366 F. Supp. 3d at 139; *see Gresham v. Azar*, 950 F.3d 93, 99 (D.C. Cir. 2020) ("The district court is indisputably correct that the principal objective of Medicaid is providing health care coverage."), *vacated on other grounds*, 142 S. Ct. 1665 (2022).

The Secretary agrees that furnishing medical assistance is "an important objective of the Medicaid program." AR 1555. However, in approving HIP, he continued to apply a different slate of objectives, such as improving health, AR 1555-57, 1563-64; increasing financial independence and facilitating the transition of Medicaid beneficiaries to commercial coverage, AR 1555-57, 1565-67; and ensuring the fiscal sustainability of the Medicaid program, AR 1556-57,1561-62. The Secretary does not have the authority to redefine the objectives set forth in the statute.

The Court has repeatedly found that improving health is not a standalone objective of the Act. *See Stewart II*, 366 F. Supp. 3d at 144; *Philbrick*, 397 F. Supp. 3d at 28. Treating health as the ultimate goal of the Medicaid Act "is nothing more than a sleight of hand," as it improperly "extrapolate[s] the objectives of the statute to a higher level of generality." *Stewart II*, 366 F. Supp. 3d at 144. While promoting health might be a desirable result of the Medicaid program, the Secretary has no authority to "choose his own means to that end." *Stewart I*, 313 F. Supp. 3d at 266 (citing *Waterkeeper Alliance v. EPA*, 853 F.3d 527, 535 (D.C. Cir. 2017)). The text and structure of the Act show that Congress "designed a scheme to address not health generally but the provision of care to needy populations." *Stewart II*, 366 F. Supp. 3d at 144; *see Gresham*, 950 F.3d at 100. Were it otherwise, the Secretary could approve any policy he concluded might improve health, including "condition[ing] coverage on a special diet or certain exercise regime." *Stewart II*, 366 F. Supp. 3d at 145.

Likewise, the Court has found that promoting "financial independence" and smoothing the transition of beneficiaries from Medicaid to commercial insurance are not standalone objectives of the Medicaid Act. *Id*. at 145-46. Congress created Medicaid to provide health coverage to people "whose income and resources *are* insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1 (emphasis added). While helping individuals increase their incomes and resources might be a laudable goal, it is external to Medicaid, which was created to ensure that people have access to care when their incomes *are* low, full stop. If Congress had wanted reducing dependence on public assistance to be a goal of Medicaid, it would have said so. *See Gresham*, 950 F.3d at 101-02 (contrasting the Medicaid Act with the TANF and SNAP statutes). Instead, the text Congress enacted in § 1396-1 "quite clearly limits [the Act's] objectives to helping States furnish *rehabilitation and other services* that might promote self-care and independence." *Stewart II*, 366 F. Supp. 3d at 146 (quoting *Stewart I*, 313 F. Supp. 3d at 271). It does not follow that restricting access to those services "would further that same end." *Id*.

Finally, to the extent that the Secretary treated fiscal sustainability as an independent objective of the Act, *see* AR at 1556-57, 1561-62, that does not save his decision. This Court has found that the Secretary may consider the effects of a proposed Section 1115 project on spending, *Stewart II*, 366 F. Supp. 3d at 149, but in doing so must adequately explain why the project "advances [fiscal sustainability] and why, if it is adverse to other Medicaid objectives, he could reasonably conclude that, on balance, it promotes the objectives of the Act," *id*. Here, the Secretary "fell short," as he made no finding about the fiscal effects of the project and did not weigh any fiscal benefits against the consequences for coverage. *Id*. at 149-50; *see* Section I.C, *infra*.

His primary finding was that policies designed to ensure the fiscal sustainability of the Medicaid program could promote coverage by "preserv[ing] states' ability to continue to provide

the optional services and coverage they already have in place," AR 1557, and "making it more viable for states to furnish medical assistance to a broader range of persons in need or providing additional benefits to existing beneficiaries," AR 1556; *see also* AR 1561-62 (concluding that waiver of NEMT will improve fiscal sustainability, which "will help Indiana to continue to cover non-mandatory benefits and eligibility groups (such as the . . . expansion population and dental and vision benefits)"). Notably, this reasoning is based on the false premise that Indiana could simply terminate coverage for the mandatory expansion population. In *NFIB v. Sebelius*, 567 U.S. 519 (2012), the Supreme Court decided a constitutional question: whether it was unduly coercive for Congress to compel a Medicaid-participating state to cover the expansion population under the threat of losing all federal Medicaid funding. The Court held that it was coercive because, prior to 2010, states did not understand they would have to cover this group as part of the Medicaid bargain. *See Id.* at 584. As the full remedy for the unconstitutional violation, the Court prohibited the Secretary from withdrawing existing federal funding from a state that refuses to take up expansion, *id.* at 586, while leaving the statute intact, *id*. at 585. *NFIB* established only whether requiring coverage of the expansion population *without a state's opt-in* was coercive. It did not deem the expansion population an optional coverage population. And following enactment of the ACA in 2010 and the Supreme Court's *NFIB* decision in 2012, states, such as Indiana, that opted-in to the Medicaid expansion understood the bargain.

Even if Indiana could terminate coverage for the expansion population, the theory that fiscal sustainability is an objective of the Medicaid Act because it could ultimately promote coverage fails for reasons the Court has already articulated. *See Stewart II*, 366 F. Supp. 3d at 153-55; *Philbrick*, 397 F. Supp. 3d at 25-27. While the theory has evolved somewhat in that it no longer rests on a state threat to drop coverage, that distinction is of no consequence.

First, the position "is not subject to any kind of limiting principle." *Stewart II*, 366 F. Supp. 3d at 154. While it is true that coverage of certain eligibility groups and services is optional, the entire Medicaid program is optional for states. As a result, the theory would mean that any project that would save the state money would be approvable because it would be "coverage promoting compared to a world in which the state offers no coverage at all." *Id*. at 154. Medicaid would become an à la carte menu, with states permitted to mix and match coverage as they wish, so long as some number of individuals remain enrolled in the program with access to some number of services. The Medicaid Act does not "leave[] the Secretary so unconstrained, nor . . . the states . . . so armed to refashion the program Congress designed in any way they chose." *Id*. at 131.

Second, as the Court has pointed out, the theory is inconsistent with the text of Section 1115. *Id*. at 154. In requiring the Secretary to evaluate whether a project is likely to assist in promoting the objectives of the Act, Section 1115 "assumes the implementation of the Act." *Id*. As a result, the relevant baseline for determining whether a waiver will promote coverage is compliance with the requirements of the statute. The limits in Section 1115 "would make little sense . . . where the relevant consideration was not full compliance with the Act's requirements but instead no engagement whatsoever in the program." *Id*.

With this approval, the Secretary took a different route to his previous destination, stating that policies that promote health or financial independence ensure the fiscal sustainability of the Medicaid program, and thus, could ultimately promote coverage. AR 1556-57, 1561-62, 1568. But this attenuated version of fiscal sustainability continues to permit the Secretary to smuggle objectives into his waiver authority that the Court has already rejected. Improving health and increasing financial independence do not suddenly become permissible considerations simply because they could advance fiscal sustainability, which in turn could promote coverage in the

future. Even if they did, the Secretary did not reasonably conclude that HIP would improve health outcomes or increase financial independence. *See* Section I.C.2., *infra*.

### C. The Secretary Failed to Adequately Examine if the HIP Project Met the Section 1115 Conditions.

The Secretary did not reasonably conclude that HIP is "likely to assist in promoting the objectives of the Medicaid Act." 42 U.S.C. § 1315(a). He failed to adequately consider whether HIP "would in fact help the state furnish medical assistance to its citizens." *Stewart I*, 313 F. Supp. 3d at 243. And his conclusion that HIP would promote his preferred objectives was not supported by the record. Similarly, his approval of HIP as an "experimental, pilot, or demonstration" project strained credulity. Finally, he found that extending HIP for another 10-year period was expedient, not that it was necessary. *See* 42 U.S.C. § 1315(a)(1).

#### 1. The Secretary Did Not Adequately Examine if the Extension Would Cause Medicaid Coverage Loss or Promote Medicaid Coverage.

Given that the core objective of the Medicaid Act is to furnish medical assistance to low-income individuals, the Secretary had to assess whether HIP "'would cause recipients to *lose* coverage' and 'whether the project would help *promote* coverage.'" *Stewart II*, 366 F. Supp. 3d at 140 (quoting *Stewart I*, 313 F. Supp. 3d at 262). He did not adequately do so, rendering the HIP approval arbitrary and capricious.

**Coverage loss**. The administrative record contains substantial evidence that each of the HIP elements—premiums and consequences for failure to pay, waiver of retroactive coverage, and elimination of NEMT—reduce health coverage among Medicaid-eligible individuals in Indiana.

*Premiums.* Commenters cited numerous studies, conducted over the course of almost two decades, finding that premiums deter and reduce coverage among low-income individuals. *E.g.*, AR 7194-95, 8097, 8197, 8206. This included evidence of the extensive coverage loss that has

occurred in Indiana due to HIP. *E.g.*, AR 7195-96, 8096-97, 8156, 8196-97. For example, over a period of 22 months in 2015 and 2016, more than 46,000 individuals who were found eligible for Medicaid were never enrolled due to failure to pay the initial premium, and 13,550 people who successfully enrolled lost coverage for failure to pay a premium. AR 5959. Overall, 55% of individuals found eligible for HIP did not pay at least one premium, meaning they never received coverage, were terminated from the program, or were shifted to a plan with fewer benefits and higher cost sharing. AR 5670. A later evaluation (included in the HIP renewal application in 2019 and finalized in 2020) revealed that coverage loss persisted: in 2017 and 2018, more than 26,000 enrollees were terminated from the program for failure to pay. AR 4764. And, as commenters highlighted, *e.g.,* AR 8098, 8111-12, 8220, the 2020 evaluation showed that Black individuals were disproportionately harmed by the HIP premiums, AR 4773-74.

In response, the Secretary "brushed aside [these] critical facts." *Am. Wild Horse Pres. Campaign*, 873 F.3d at 932. First, he claimed that the 2020 evaluation showed that beneficiaries generally find the premiums affordable and that coverage loss due to the premiums declined between 2016 and 2018. AR 1570. But comments noted that: (1) the decline was small and could be due to confounding factors, including the increase in the number of beneficiaries determined medically frail; (2) many thousands of people lost coverage for failure to pay during that period; and (3) the evaluation did not include the number of individuals who were never enrolled in coverage due to failure to pay premiums, despite the concerning data on that point in the 2017 evaluation. AR 7196, 8219-20.

Second, the Secretary claimed that Indiana had previously taken steps to minimize coverage loss by: (1) exempting pregnant women and individuals who are medically frail from disenrollment for failure to pay, AR 1565-66; and (2) placing an aggregate cap on premiums and

cost sharing, AR 1570-71. "That response, however, is no answer at all," *Stewart I*, 313 F. Supp. 3d at 263. The aggregate cap and exemptions are not new features of the project and did not protect against the substantial coverage loss documented in the record.

Finally, the Secretary noted that he can suspend implementation if "monitoring or evaluation findings indicate substantial and sustained directional change inconsistent with state targets." AR 1564. Given the substantial and sustained coverage loss that has already occurred, one wonders what findings would prompt the Secretary to order a suspension. Indeed, on the eve of the 2020 approval, Indiana stated that it "anticipat[ed] a substantial increase in disenrollment" for failure to pay premiums after the end of the public health emergency, AR 3302, and the Secretary nevertheless issued the approval.

In the face of the uncontroverted evidence showing that the premiums and associated penalties for failure to pay would continue to cause coverage loss, the Secretary failed to "address the *magnitude* of that loss," *Philbrick*, 397 F. Supp. 3d at 24, and instead extended the premiums for another decade.

*Retroactive coverage.* The Court has twice observed that "'restricting retroactive eligibility will, by definition, *reduce* coverage.'" *Stewart II*, 366 F. Supp. 3d at 143 (quoting *Stewart I*, 313 F. Supp. 3d at 265). The record here included dozens of well-founded comments stating that eliminating retroactive coverage creates gaps in coverage and reduces access to Medicaid services. *E.g.*, AR 7203-06, 8207, 8213. Data from Indiana verified the effects of the waiver: nearly 14% of parents and caretaker relatives who enroll in HIP need retroactive coverage, as they have incurred, on average, $1,561 per person in medical bills during the retroactive eligibility period. AR 7203. While the Secretary acknowledged that commenters raised coverage loss as a concern, he made no meaningful attempt to address that concern. *See Getty*, 805 F.2d at 1055 ("[S]tating that a factor

was considered . . . is not a substitute for considering it.") He reiterated that the waiver is designed to advance his preferred objectives. AR 1571. Then, he suggested that the waiver will not cause coverage loss because Indiana will continue to provide "outreach and education about how to apply for and receive HIP coverage," presumptive eligibility, and the "Fast Track" enrollment option. AR 1564-65. However, these are long-standing features of the project that commenters pointed out cannot replace retroactive coverage. *See, e.g.*, AR 7204 (describing why presumptive eligibility is not a substitute for retroactive coverage), 8094-95 (noting widespread confusion about eligibility and the Fast Track option).

*NEMT*. Eliminating coverage of NEMT for the expansion population will, by definition, reduce coverage. The Secretary failed to adequately consider the many comments showing that the loss of NEMT would impede access to care. *See, e.g.,* AR 7162, 7213-16, 8112-13, 8223-29. He suggested that Indiana adequately addressed commenters' concerns about "vulnerable beneficiaries" by exempting pregnant women, beneficiaries who are medically frail, and parents and caretakers. AR 1572. Once again. that response "is no answer at all," *Stewart I*, 313 F. Supp. 3d at 263. The exemptions are not new, and commenters expressed concerns about the effects of the waiver on low-income people generally. *E.g.*, AR 7213, 8113, 8226. And as the Court has previously found, the Secretary "cannot limit his review to only 'vulnerable individuals,'" but must consider how the project affects all enrolled groups. *Stewart I*, 313 F. Supp. 3d at 263-64. In addition, the Secretary suggested that the 2016 evaluation of NEMT showed that the waiver has had no "adverse effects" on beneficiaries. AR 1572; *see also* AR 1562. As comments explained, *e.g.*, AR 7214-15, 8112, the evaluation was deeply flawed, and the Secretary ignored its basic finding that lack of transportation did cause many beneficiaries to miss scheduled appointments. AR 6050-56; *Am. Wild Horse*, 873 F.3d at 923 (explaining that the agency must "examine all

relevant factors and record evidence"). In sum, the Secretary extended HIP "with no idea of how many people might lose Medicaid coverage and thus 'failed to consider an important aspect of the problem.'" *Stewart II*, 366 F. Supp. 3d at 142-43 (quoting *Stewart I*, 313 F. Supp. 3d at 264).

**Coverage promotion.** The Secretary did not reasonably explain how the project will promote coverage. In the section of the approval letter indicating that the project will expand coverage, the Secretary pointed only to the SUD/SMI program. *See* AR 1561, 1578-79. As described above, that program is separate from the HIP project. Even if it were not, the Secretary failed to ask whether the project would, "on balance" promote coverage. *Stewart I*, 313 F. Supp. 3d at 265. As in *Stewart I*, he did not suggest that providing institutional services to individuals with SUD/SMI would outweigh the loss of coverage due to the premiums and the waivers of retroactive coverage and NEMT. *See id*. (noting that individuals who lose coverage will not be able to take advantage of the SUD treatment and that much of the expansion population does not have a SUD).

In a separate section of the approval letter, the Secretary stated that Indiana is "testing whether waiving retroactive eligibility for certain groups of Medicaid beneficiaries will encourage them to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible." AR 1571-72. To the extent that his remark could be construed as asserting that the waiver would promote Medicaid coverage, the Court has already found that it is a "conclusory reference" that "cannot suffice, especially when viewed in light of an obvious counterargument." *Stewart II*, 366 F. Supp. 3d at 143 (quoting *Stewart I*, 313 F. Supp. 3d at 265) (cleaned up). There is no evidence in the record showing that low-income individuals decide not to enroll in Medicaid because they are healthy. *Cf*. AR 7204-05, 8207, 8213 (explaining that many people are not aware that they are eligible and/or are not able to submit an application

immediately when they learn that they are eligible). The idea that withholding coverage and services will somehow promote the furnishing of coverage and services is nonsensical. In any event, the Secretary made no effort to quantify any potential gains in coverage due to the waiver of retroactive coverage or to weigh the speculative gains against the well-documented coverage loss due to HIP. He did not "'adequately analyze the . . . consequences'" of the approval. *Stewart II*, 366 F. Supp. 3d at 143 (citation omitted); *see Philbrick*, 397 F. Supp. 3d at 25.

**2. The Secretary Did Not Reasonably Conclude that the Project Would Further His Preferred Alternative Objectives.**

To the extent that the Secretary could have properly considered his preferred objectives, he did not reasonably determine that HIP was likely, on balance, to achieve them. Indeed, the Secretary made no finding that, without the conditionally approved features, HIP was likely, as a whole, to achieve his preferred goals. *Cf.* AR 1566 ("If implemented as intended following a favorable Supreme Court decision authorizing full implementation, and successful in its objectives, HIP would improve health outcomes, promote increased upward mobility, and improve quality of life, increase individual engagement in health care decisions, and prepare individuals who transition to commercial health insurance coverage to be successful in this transition."). And, he entirely failed to weigh the purported benefits "against the consequences of lost coverage, rendering his determination arbitrary and capricious." *Stewart II*, 366 F. Supp. 3d at 149.

**Health.** As in *Stewart*, the Secretary made the implausible claim that requiring people to pay premiums and cost-sharing would improve their health outcomes. AR 1563. In support of his claim, he pointed to data in a 2020 evaluation showing that HIP Plus beneficiaries (who paid premiums) utilized more services than HIP Basic beneficiaries (who did not). AR 1563-64. Here, the Secretary confused correlation for causation. *See Tex Tin Corp. v. EPA*, 992 F.2d 353, 355-56 (D.C. Cir. 1993) (rejecting agency prediction where its reading of the studies "confuse[d]

correlation with causation"). The authors of the evaluation noted that a number of factors, including "case mix . . . health literacy, [and] lack of transportation," could contribute to differences in utilization. AR 4659. Commenters explained that a probable explanation is that the required cost sharing has deterred utilization of services in HIP Basic. *E.g.*, AR 7216-18, 8110-11, 8200. The Secretary provided no other evidence supporting his contention that premiums promote health. While he suggested that the tobacco surcharge would improve health outcomes, the evidence in the record shows that these kinds of penalties deter individuals from enrolling in coverage and do not help people stop smoking. *See, e.g.*, AR 7197-98, 8156-57, 8212.

In addition, the Secretary argued that the waiver of retroactive coverage is designed to improve health outcomes by "improving uptake of preventive services" by encouraging individuals to enroll in Medicaid, even when healthy. AR 1564, 1571. As explained above, that claim defies logic and runs counter to the evidence in the record.

What is more, the Secretary entirely failed to weigh the purported health benefits of the project against the serious health harms that result from coverage loss, and that are well-documented in the record. *See, e.g.* AR 7210-13 (citing literature showing the connection between coverage and positive health outcomes), AR 8210 (same), AR 8113 (discussing the link between NEMT and health outcomes), AR 8228-29 (same), AR 7199-02 (citing research showing the association between cost sharing and poor health outcomes and discussing the health benefits of dental and vision services). Without estimating the number of individuals who would lose coverage due to HIP, the Secretary could not have adequately assessed the magnitude of the health harms, weighed the harms against any health benefits, or weighed any net health benefits against coverage loss. *See Stewart II*, 366 F. Supp. 3d at 145.

**Facilitating transition to commercial coverage.** The Secretary claimed that the premiums and the waivers of retroactive coverage and NEMT would prepare beneficiaries for commercial insurance. AR 1571. The record does not support that conclusion. The Secretary did not attempt to estimate the number of people who will successfully transition to commercial coverage or to explain the "mechanism by which they are likely to do so." *Stewart II*, 366 F. Supp. 3d at 147. Other than claiming that the conditionally-approved work requirements would move some beneficiaries onto commercial coverage, AR 1562, the Secretary made no attempt to explain how the HIP project would accomplish that goal. *Stewart II*, 366 F. Supp. 3d at 147. It is illogical to suggest that giving beneficiaries "the tools to successfully utilize" commercial coverage will somehow provide them with access to that coverage. AR 1565.

Moreover, multiple commenters explained that the HIP features do not actually mirror commercial coverage. *E.g.*, AR 7216 (explaining that the POWER account does not resemble a high-deductible health savings account), AR 8156 (discussing the difference in how premiums are paid in HIP and in commercial plans), AR 8226-27 (noting the increase in commercial plans offering NEMT).[1] Finally, even if HIP would somehow help some number of beneficiaries successfully transition to commercial coverage, the Secretary did not weigh the benefits "against the consequences of coverage loss, which would harm and undermine the financial self-sufficiency of others." *Stewart II*, 366 F. Supp. 3d at 148; *see, e.g.*, AR 7211-13 (citing research showing the link between continuous coverage and financial well-being).

[1] The approval also means that individuals enrolled in HIP will be required to pay monthly premiums while higher income Hoosiers who have commercial coverage through the ACA Marketplace will not. *See* Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 12001(a), 136 Stat. 1818, 1905 (amending 26 U.S.C. § 36B(b)(3)(A)(iii)).

**Fiscal sustainability.** The Secretary did not reasonably determine that HIP would enhance the fiscal sustainability of Medicaid and thus, ultimately promote coverage. First, he "made no finding that [HIP] would save [Indiana] any amount of money or otherwise make the program more sustainable in some way." *Stewart II*, 366 F. Supp. 3d at 149; *see Philbrick*, 397 F. Supp. 3d at 29. This is especially problematic given the evidence in the record contradicting any suggestion that the project would promote fiscal sustainability. For example, the Secretary suggested that the waiver of NEMT would enable the State to stretch its limited resources, AR 1561-62, but commenters cited the literature showing that NEMT is cost-effective, *e.g.*, AR 7215, 8113, 8224-25. The fact that managed care plans are choosing to provide some level of NEMT without reimbursement from the State, AR 1562, further confirms this point. Indeed, Indiana explicitly told CMS that it did not request the NEMT waiver to save money, but to align HIP with commercial plans. AR 3300; *Philbrick*, 397 F. Supp. 3d at 29, 31 (pointing to the "glaring disconnect" in the federal and state positions on fiscal sustainability as a reason for finding the approval arbitrary and capricious). In addition, commenters noted that the cost of charging enrollees premiums often exceeds the amount of the premiums collected. AR 7201. And while the Secretary contended that the project would save money by improving health and moving beneficiaries onto commercial coverage, the evidence in the record simply does not support that claim, as described above.

Second, there is no evidence in the record that without the approval, Indiana could not afford to continue covering optional populations or services. AR 1562. Nothing in the record shows that the Indiana Medicaid program is "actually at risk" of financial collapse. *Stewart I*, 313 F. Supp. 3d at 271. The Secretary pointed to no information about the budget situation in Indiana, nor did he explain why "cuts to the expansion population would be the best remedy for any budget woes," given that states receive 90% federal funding for that population. *See id*. Without this

information, the Secretary could not make a reasoned decision that the project would enable Indiana to maintain current coverage levels. *Id.* at 271. Finally, the Secretary failed to "compare the benefit of savings to the consequences for coverage," rendering his conclusion arbitrary and capricious. *Stewart II*, 366 F. Supp. 3d at 150; *see Philbrick*, 397 F. Supp. 3d at 30.

**3. The Secretary Did Not Adequately Examine if the Extension Was Experimental.**

The Secretary can only use a Section 1115 waiver for an "experimental, pilot, or demonstration project." 42 U.S.C. 1315(a). As a result, the Secretary "must make some judgment that the project has a research or a demonstration value." *Beno v. Shalala,* 30 F.3d 1057, 1069 (9th Cir. 1994). He must inquire "into the merits of the experiment" and "determine that the project is likely to yield useful information or demonstrate a novel approach to program administration." *Id*. The Secretary failed to adequately do so here.

The policies that Indiana is purporting to continue to test—premiums and the elimination of retroactive coverage and NEMT—have been in place since 2008. *See* 2007 STCs at 46-49. Even assuming the policies were experimental at that time, the Secretary did not address how they could possibly remain so nearly 13 years later. While he did say that Indiana has been unable to accomplish a "comprehensive and conclusive" evaluation of the longstanding policies, AR 1558, that rationale cannot be sufficient. It would allow CMS to renew a project in perpetuity, so long as the state failed to conduct a flawless evaluation of its effects. *Cf. Cal. Welfare Rights Org. (CWRO) v. Richardson*, 348 F. Supp. 491, 498 (N.D. Cal. 1972) (noting that "the Secretary would abuse his discretion" if he were to continue a project "for an unreasonably long period").

In addition, that rationale ignores that HIP policies have been tested repeatedly in other states. As comments explained, redundant and consistent studies, conducted over the course of two decades, have concluded that premiums make low-income people less likely to enroll in coverage

and more likely to drop coverage and become uninsured. *E.g.*, AR 7194-95, 8197, 8206. Given that, the Secretary could not have reasonably concluded that the premiums "will actually demonstrate something different" than the existing research. *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (finding the Secretary could not have reasonably concluded that cost sharing was experimental given the cost sharing research conducted over the prior 35 years). The addition of the tobacco surcharge in 2018 does not change the result. As explained above, the existing research does not support the notion that the surcharge will improve health outcomes. Commenters also noted that the State was not conducting a legitimate evaluation of the surcharge, AR 7197-99, and nothing in the approval letter addressed that issue.[2] *See also* CMS, CMCS Informational Bulletin: Strategies to Improve Delivery of Tobacco Cessation Services (Mar. 7, 2024), https://www.medicaid.gov/sites/default/files/2024-03/cib03072024.pdf (outlining five strategies to increase use of cessation services and including no mention of financial penalties). More fundamentally, the Secretary cannot continue to deem a project experimental (and allow a state to evade foundational Medicaid Act requirements) simply because the state has tweaked its contours. Again, that would allow CMS to renew a project in perpetuity, so long as the state made minor programmatic changes every few years.

Finally, the Secretary attempted to justify the approval by noting that he was requiring Indiana to collect and submit additional data about the effects of HIP. AR 1563, 1558, 1571. Data collection does not transform a proposal into a valid experiment. If it did, then absolutely any

[2] Comments also explained why the waivers of retroactive coverage and NEMT have no ongoing research or demonstration value, pointing to the truly implausible outcomes suggested by the Secretary. *See* Sections I.C.2. and I.C.3., *infra*. In addition, as comments noted, AR 7216, the fact that the managed care plans are providing NEMT to individuals in the expansion population (without reimbursement from the State) undermines any suggestion that Indiana is actually testing the effects of the waiver.

proposed project could satisfy the experimental requirement of Section 1115. *Cf.* S. Rep. No. 87-1589, at 19-20 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62 (noting that projects are expected to be "selectively approved" and limited to those "designed to improve the techniques of administering assistance and the related rehabilitative services").

### D. The Secretary's Decision to Extend HIP for a 10-Year Period Cannot Stand.

#### 1. The Extension Violates Section 1115(e) and (f).

In approving the 2020 HIP extension, the Secretary exceeded his authority under Section 1115. Congress placed requirements in Section 1115 to govern the extension of "state-wide comprehensive demonstration projects," such as HIP. 42 U.S.C. § 1315(e), (f). Subsection (e) outlines the requirements for an initial extension of a project. *Id*. § 1315(e)(1) (noting the provisions of the subsection "apply to the extension of any State-wide comprehensive demonstration project . . . for which a waiver of compliance with requirements of subchapter XIX is granted under subsection (a)"). It limits the first extension of an approved project to a period of up to three years, or in the case of a waiver involving dual eligibles, five years. *Id*. § 1315(e)(2). Subsection (f) then establishes the requirements for a subsequent extension of a state-wide comprehensive project. *Id*. § 1315(f) ("An application . . . for an extension of a waiver project the State is operating under an extension under subsection (e) . . . shall be submitted and approved or disapproved in accordance with the following. . . ."). It limits the second extension to "a period not to exceed three years (five years, in the case of a waiver [involving dual eligibles])." *Id*. § 1315(f)(6).

Where the text of the statute is clear, there is nothing for the Secretary to do but apply it. *See*, *e.g.*, *Gross v. FBL Fin. Servs., Inc*., 557 U.S. 167, 175 (2009) ("Statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of

that language accurately expresses the legislative purpose.") (citation omitted); *Caminetti v. United States*, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain, . . . the sole function of the courts is to enforce it according to its terms."). The text of Section 1115 is clear. The Secretary may only extend an approved state-wide, comprehensive demonstration project not involving dual eligibles twice, each time for up to three years. The statute does not permit the Secretary to extend the HIP project for a third time.

There is no reason to depart from the ordinary textual reading here. In fact, given the nature of Section 1115, there is every reason to hold to it. From the get-go, Section 1115 limits the Secretary to approving an experiment, that is "a trial conducted for the purpose of testing a proposition." *CWRO*, 348 F. Supp. at 498. To this end, the waiver of the otherwise mandatory congressional requirements can last only as long as necessary to test the proposition.

HIP has operated as a statewide, comprehensive demonstration project since 2008. Prior to the 2020 approval, the Secretary had already extended the project several times between 2012 and 2015, in 2015 (for 3 years), and in 2018 (for 3 years). The Secretary did not have the authority to approve yet another extension of HIP.

**2. The Secretary Did Not Reasonably Find that the Length of the HIP Extension Was Necessary.**

Even assuming that the Secretary had the authority to extend HIP yet again, this time for a decade, his approval did not constitute reasoned decision-making. When issuing a Section 1115 approval, the Secretary must at least make a finding that the length of the approval is necessary to allow the state to conduct its experiment. *See* 42 U.S.C. § 1315(a)(1); *Stewart I*, 313 F. Supp. 3d at 257; *Beno*, 30 F.3d at 1069 (noting that the Secretary "must, at a minimum, examine" that issue). The Secretary did not do that here.

The approval letter lists the three factors that the Secretary took into consideration to determine the approval period of the various HIP components: 1) Indiana's request; 2) whether the "the authorities. . . had been previously or currently implemented over a sufficient period of time to support" a 10-year extension; and 3) "the importance, performance, and potential effectiveness" of the components. AR 1557-58. Thus, the Secretary expressly did not consider whether an additional 10-year period was necessary to allow the State to carry out an experiment.[3]

The Secretary did find that it has been difficult to accomplish a "comprehensive and conclusive" evaluation of many of the HIP elements due to "programmatic changes" made with each extension. AR 1558. Thus, he suggested that the 10-year approval "may facilitate" a more rigorous evaluation of the elements. *Id*. To the extent that could be construed as a finding that the 10-year approval was necessary, the finding was arbitrary and capricious. First, it implies that the effects of the elements are unknown, when in fact, they are well-known, as the record before him established. Instead of the evidence being "promising," *see id.*, it overwhelmingly indicates that the HIP features lead to coverage loss and have no countervailing benefits. Second, the Secretary permitted Indiana to make changes to premiums over the course of the project without submitting an amendment, *see* AR 1559, calling into question his claim that the 10-year approval will provide the programmatic consistency necessary for a more rigorous evaluation. Third, as explained above, it is unreasonable to suggest that Congress intended to allow the Secretary to renew a project for a 10-year period on the basis that the State has not managed to conduct a proper evaluation, despite having ample opportunity to do so. Finally, the approval runs counter to existing CMS policy, under which CMS may grant a 10-year approval of "routine, successful, non-complex" waivers.

[3] The three factors do illustrate that the agency has the relevant inquiry backwards. Section 1115 requires an experiment. The fact that components of HIP have been implemented for a long period of time cuts against any claim that it is necessary to extend them for a 10-year period.

*See* 2017 Informational Bulletin at 3. Putting aside that the policy itself runs afoul of Section 1115, the Secretary did not reasonably explain how the HIP elements can be both untested, as he suggested, and successful at the same time. And, the premiums and POWER accounts are so complex that beneficiaries and providers struggle to understand them. AR 7216-19, 8094-95, 8212, 5980-82. Because the Secretary failed to "articulate a satisfactory explanation" for his decision to extend HIP for another decade, the approval was arbitrary and capricious. *Motor Vehicle Mfrs. Ass'n of U.S.*, 463 U.S. at 43.

## II. The Secretary's December 2023 Decision Allowing HIP to Proceed Violated the Administrative Procedure Act.

On December 22, 2023, CMS issued a decision letter, announcing it "ha[d] concluded [its] review of the authorities approved in the HIP demonstration" and was allowing Indiana to move forward with HIP. AR 0001. This final decision violates the APA's bar on arbitrary and capricious agency decision-making. The Secretary rightfully spent page after page explaining why imposing heightened premiums on Medicaid beneficiaries is at odds with Medicaid's core purpose of providing coverage to those who cannot otherwise afford it. The agency nevertheless made a decision contrary to that evidence, allowing Indiana to maintain the HIP premiums on the grounds that doing otherwise would be "too disruptive." This, despite the fact that these premiums have not been in force for nearly four years. That is the epitome of arbitrary decision making. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc.*, 463 U.S. at 43 (agency's explanation must include "a rational connection between the facts found and the choice made") (citation omitted). What is more, in permitting Indiana to move forward with the premiums—as approved in 2020—the Secretary exceeded his statutory authority, as non-waivable provisions of the Medicaid Act prohibit imposing premiums on the HIP population groups.

### A. The Letter's Rationale—Preventing Disruption to the COVID-19 Unwinding Process—Is Illogical.

The letter's stated reason for continuing the waiver authorities does not withstand even minimal scrutiny. The only reason offered for the decision is that to not allow Indiana to impose premiums would be "too disruptive, particularly in the context of the state *needing to maintain focus on keeping people covered* through [the COVID-19] Medicaid unwinding." AR 0001 (emphasis added). But as the letter acknowledges in the very next paragraph, "[t]he premium requirement and associated penalties . . . were halted on March 1, 2020 . . . and have not been reinstated to date." *Id*. The idea that retaining the status quo (no premiums) would be "too disruptive" is the antithesis of rational decision-making. Common sense dictates that the reintroduction of a requirement for Medicaid beneficiaries, with which they have not had to comply for nearly four years, will be considerably more disruptive for them and for the State. Many beneficiaries, including two of the plaintiffs, enrolled in HIP after the premiums were suspended and have never had to comply with this requirement.

Also puzzling is that just one month prior, in November 2023, the Secretary made the opposite decision for Wisconsin despite the same backdrop of the COVID-19 unwinding. *See* Letter from Daniel Tsai, Deputy Admin. and Dir. CMCS, to Jamie Kuhn, State Medicaid Dir., Wis. Dep't of Health Servs. (Nov. 17, 2023), https://bit.ly/4aaPrlP ("2023 Wisconsin Letter"). Rather than assert that removing the premium requirement from the project would disrupt Wisconsin's unwinding efforts, he specifically prohibited Wisconsin from implementing the requirement during the unwinding process. *See id*. at 3 (prohibiting the State from taking "adverse action" on beneficiaries). *See, e.g.*, *Prairie Band Potawatomi Nation v. Yellen*, 63 F.4th 42, 47 (D.C. Cir. 2023) ("[T]reat[ing] similar situations in dissimilar ways [can be] contrary to the principles of reasoned decisionmaking.") (quotation marks omitted); *Kort v. Burwell*, 209 F. Supp.

3d 98, 115 (D.D.C. 2016) (finding agency's failure to adequately explain why it denied Medicare coverage for one test but not another despite manifest similarities was arbitrary and capricious).

Equally confounding, the Indiana letter states that if the State determined that it could decline to restart premiums without impacting the State's COVID-19 unwinding efforts, the Secretary "encourages the state to do so," noting "CMS would be available to provide technical assistance on mitigating any operational challenges from such a termination, including charting a path to do so without causing undue beneficiary loss of coverage from errors in eligibility determinations processes." AR 0002. This constitutes an acknowledgement by the Secretary of an available alternative approach– providing Indiana with technical assistance—that would prevent the asserted "disruption" to unwinding efforts. The letter includes no discussion regarding why the agency made the decision it did as opposed to offering this technical assistance that CMS believes could minimize disruption without leading to harm and coverage loss for beneficiaries. *See Walter O. Boswell Mem'l Hosp.*, 749 F.2d at 797 ("[A]n agency must . . . explain its reasons for rejecting alternatives in sufficient detail."); *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 817 (D.C. Cir. 1983) (explaining that an agency decision must be vacated when "the agency's explanation could not justify its drastic decision" over a more modest approach). Further, CMS failed to consider another "reasonably obvious" alternative—requiring Indiana to wind down the premiums after the unwinding process ends this summer. *Walter O. Boswell Mem' Hosp.*, 749 F.2d at 797; *see* Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Dawn Stehle, Deputy Dir. for Health & Medicaid, Ark. Dep't of Hum. Servs. 2 (Dec. 21, 2021), https://bit.ly/3IJa9Nj ("2021 Arkansas Letter") (allowing State one year to phase-out premiums); Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Marie Matthews, Medicaid Dir., Mont. Dep't of Pub. Health & Hum. Servs. 1 (Dec. 21, 2021), https://bit.ly/49WKi0Ah ("2021 Montana Letter") (same). After all, the

idea that withdrawing the waiver authorities would be "too disruptive" during unwinding cannot possibly explain why the agency permitted HIP to continue through the end of 2030. [4]

### B. The Letter Makes Clear That the Conclusion to Allow Indiana to Reinstate Premiums Contradicts All Evidence.

The letter is unique in announcing a decision that flies in the face of the substantial, uncontroverted evidence set forth *in the same letter*. AR 0004-10. Over eight pages, the Secretary discusses the "large body of evidence suggesting that premiums beyond those authorized under the Medicaid statute may reduce access to coverage and care among populations that Medicaid is designed to serve." AR0004. The letter even includes robust data on the detrimental effects of premiums on Medicaid beneficiaries *in Indiana*. *See id*. It acknowledges that the evidence is entirely one-sided:

> CMS is not aware of specific evidence from any state that demonstrates that charging premiums beyond those authorized under the statute to beneficiaries who would otherwise be eligible for coverage, on its own, facilitates coverage directly or indirectly. On the contrary, evidence from research across several states on premium policies in section 1115 demonstrations seems to suggest that premiums may reduce access to coverage and care among populations that Medicaid is meant to serve. AR 0010.

Given the evidence, it is not surprising that CMS recently required three other states to remove premium requirements from Section 1115 projects. In its letter to each of these states, the agency explained: "CMS has determined that premiums can present a barrier to coverage, and therefore, charging beneficiaries premiums beyond those specifically permitted under the Medicaid statute are not likely to promote the objectives of Medicaid." 2023 Wisconsin Letter at 1; 2021 Arkansas Letter at 2; 2021 Montana Letter at 1. The decisions in these states were

[4] While the approval noted concern that taking Indiana's attention away from the unwinding could result in beneficiaries being disenrolled or not enrolled in a timely way, it did not weigh that coverage loss against the coverage loss that would result from allowing Indiana to reinstate the premiums.

supported in part by data collected in Indiana. What is surprising is that CMS somehow reached a different conclusion in Indiana, despite no change in the evidence. Accordingly, it is impossible to say that the "agency examined the relevant data and articulated a satisfactory explanation for its action including *a rational connection between the facts found and the choice made*." *Am. Clinical Lab'y Ass'n v. Becerra*, 40 F.4th 616, 624 (D.C. Cir. 2022) (cleaned up, emphasis added). The evidence put forth by CMS itself cannot support the decision to allow Indiana to impose premiums on Medicaid beneficiaries. To the contrary, the evidence "belies the agency's conclusion, [and therefore] the court must undo its action." *Cnty. of Los Angeles v. Shalala*, 192 F.3d 1005, 1021 (D.C. Cir. 1999).

### C. The Letter Provides No Explanation Whatsoever for Its Decisions on Retroactive Eligibility and NEMT.

Finally, while the letter announces the Secretary's final decision to allow Indiana to move forward with multiple waiver authorities, its only substantive discussion relates to the premium requirement. The letter does not suggest that the Secretary even considered the negative impact on beneficiaries of allowing Indiana to continue its waivers of retroactive coverage and NEMT. Agency decision making is arbitrary and capricious when the agency "entirely failed to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n of U.S., Inc.*, 463 U.S. at 43. The agency must "reasonably consider the relevant issues." *FCC v. Prometheus Radio Project*, 592 U.S. 414 (2021). The letter does not indicate that the agency "examin[ed] the relevant data" regarding either of these requirements before making a final decision to maintain them. *Am. Clinical Lab'y Ass'n*, 40 F.4th at 624. Accordingly, the decision to allow Indiana to proceed with the waiver of these requirements is arbitrary and capricious.

### D. The Approved Premiums Violate Sections 1396o and 1396o-1.

The 2023 decision, as well as the 2020 approval, fail for an additional reason—the Secretary does not have the authority to approve the requested premiums. The Medicaid Act contains two provisions—Section 1396o and Section 1396o-1—that prohibit states from imposing premiums on individuals described in Section 1396a(a)(10)(A) (*i.e.*, categorically needy groups) with incomes below 150% of FPL. The first, Section 1396o, prohibits states from charging enrollees an "enrollment fee, premium, or similar charge," except as permitted under Section 1396o(c). 42 U.S.C. § 1396o(a)(1). Subsection (c) allows states to impose premiums on specific categories of enrollees whose household incomes are above 150% of FPL. *Id.* § 1396o(c). The second, Section 1396o-1, also prohibits states from imposing premiums on enrollees with income below 150% of FPL. *See id*. § 1396o-1(b)(1)(A), (a)(2)(A). The Section 1115 authority extends only to waivers of Section 1396a. *See id.* § 1315(a)(1). As such, Section 1115 does not allow the Secretary to waive the premium and cost sharing limits set forth in Sections 1396o or 1396o-1. *See Pharm. Rsch. & Mfrs. of Am. v. Thompson*, 251 F.3d 219, 222 (D.C. Cir. 2001) (Section 1115 "does not authorize [the Secretary] to waive . . . [§ 1396o's] requirement that Medicaid beneficiaries contribute no more than a 'nominal' amount to the cost of medical benefits they receive.").

The Secretary *acknowledges* that his Section 1115 authority is limited to waiving requirements in Section 1396a—a provision that contains no substantive limits on premiums. Nonetheless, he ignores Congress's crafted scheme by waiving Section 1396a(a)(14) "insofar as it incorporates Sections 1916 [1396o] and 1916A [1396o-1]." AR 1575. That is both textually wrong and inconsistent with Congress's enactment of Sections 1396o and 1396o-1.

To begin, Section 1396a(a)(14) does not reference Section 1396o-1, so it cannot incorporate it. And while Section 1396a(a)(14) does refer to Section 1396o, the text, structure, and history of the Medicaid Act show that this reference does not incorporate Section 1396o into Section 1396a(a)(14) such that it can be waived pursuant to Section 1115. As for the text, Section 1396o has its own separate demonstration waiver provision, Section 1396o(f), which is even more restrictive than Section 1115. *See* 42 U.S.C. § 1396o(f) (permitting waiver of cost sharing (*e.g.*, copayment) requirements only if, after public notice and comment, the Secretary finds that the proposed project will meet five tightly circumscribed criteria). What is more, Section 1396o(f) *explicitly provides* that "[n]o deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary," except as provided in Section 1396o and Section 1396o-1. *Id.* Congress did not include a provision in Section 1396o allowing the Secretary to waive the premium requirements. Thus, under the well-established interpretive canon, *expressio unius est exclusio alterius*, they are not waivable. *See Sebelius v. Cloer*, 569 U.S. 369, 378 (2013). Further, if the Secretary could use Section 1115 to waive the requirements in Section 1396o, then Section 1396o(f) would be superfluous as (despite its express wording) it could be waived as well. *See, e.g.*, *Laurel Baye Healthcare of Lake Lanier, Inc. v. NLRB*, 564 F.3d 469, 472 (D.C. Cir. 2009) (noting that interpretations creating superfluity are disfavored). Moreover, Section 1396a(a)(14) states that premiums and cost sharing may be imposed "only as provided in section 1396o." 42 U.S.C. § 1396a(a)(14). This is the only place in Section 1396a where Congress uses the phrase "only as provided in." That unique language, combined with the more precise waiver authority of Section 1396o(f), indicates that Congress intended to place premiums and cost sharing outside the Secretary's Section 1115 authority.

The history and structure of Sections 1396a(a)(14) and 1396o make this intention clear. When Congress passed Medicaid in 1965, it allowed states to impose premiums and cost sharing on enrollees, as long as the amount was "reasonably related" to their financial situation. Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(14), 79 Stat. 286, 346. In 1972, Congress amended Section 1396a(a)(14) to ensure that Medicaid remained affordable. It allowed states to impose premiums on enrollees who qualified through the optional "medically needy" category (but not the categorically needy). Cost sharing was prohibited for mandatory services provided to the categorically needy and limited to "nominal" amounts for optional services. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 208(a)(14)(A), 86 Stat. 1329, 1381 (1973) (codified at 42 U.S.C. § 1396a(a)(14) (1974)).

During the 1970s, two courts upheld the Secretary's Section 1115 authority to waive Section 1396a(a)(14) and allow states to impose heightened cost sharing. *See Crane v. Mathews*, 417 F. Supp. 532, 538-40, 543 (N.D. Ga. 1976); *CWRO*, 348 F. Supp. 491. Congress responded by removing the substantive provisions on premiums and cost sharing from Section 1396a(a)(14) and creating Section 1396o—outside of Section 1396a—to address premiums and cost sharing. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 131, 96 Stat. 324, 367. Significantly, Section 1396o imposes independent requirements on states.[5] *See* 42 U.S.C. § 1396o(a), (b) (stating "the State plan shall provide . . . .").

The legislative history of Section 1396o also confirms that Congress did not intend to incorporate Section 1396o into Section 1396a(a)(14); rather, Congress expressly intended for

[5] If Congress intended for Section 1396o to have no independent legal significance, but merely to flesh out Section 1396a, it would have at least referenced Section 1396a in Section 1396o. It was logical for Congress to keep Section 1396a(a)(14) as a cross-reference to Section 1396o—that ensured that Section 1396a remained an exhaustive list of all required state plan elements.

Section 1396o to insulate premiums and cost sharing from the Secretary's Section 1115 waiver authority. *See* H.R. Rep. No. 97-757, pt. 1, at 6 (1982) (noting that states have sought Section 1115 waivers for cost sharing and finding that "this bill gives the States sufficient flexibility in this regard to make further exercise of the Secretary's demonstration authority unnecessary").

Further, in the decades since 1982, Congress has consistently confirmed that the flexibility available to states with respect to premiums and cost sharing comes from Congress. *See*, *e.g.*, Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101(d)(1), 101 Stat. 1330, 1330-141 to -142 (authorizing premiums on pregnant women and infants with incomes over 150% of FPL); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6408(d)(3)(B), (C), 103 Stat. 2106, 2269 (codified at 42 U.S.C. § 1396o(d)) (authorizing premiums on working individuals with disabilities with incomes over 150% of FPL); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5006(a)(1)(B), 123 Stat. 111, 505 (codified at 42 U.S.C. § 1396o(j) (2012)) (prohibiting premiums for Native Americans); Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 1906A, 123 Stat. 8, 61-63 (codified at 42 U.S.C. § 1396e-1) (allowing states to implement premium assistance subsidies to certain Medicaid-eligible children who enroll in employer-sponsored health plans if they maintain the premium protections set forth in §§ 1396o and 1396o-1).

In sum, Section 1396o painstakingly delineates the premiums and cost sharing states may charge to different groups of Medicaid recipients. Congress would not go to the trouble of spelling out in detail exactly who can be charged and how much—all with an eye to "mak[ing] further exercise of the Secretary's demonstration authority unnecessary"—if the Secretary could come along and waive these carefully delineated restrictions altogether. H.R. Rep. No. 97-757, pt. 1, at 6 (1982)*; see Ross v. Blake*, 578 U.S. 632, 641-42 (2016) ("When Congress amends legislation,

courts must presume it intends [the change] to have real and substantial effect." (internal quotations and citations omitted)); *Beno*, 30 F.3d at 1068-69 (noting that mandatory language and detailed requirements evidence congressional intent to take decisions away from states).

## III. The 2020 Approval and the 2023 Decision Should Be Vacated.

The HIP approval should be vacated. "When a court concludes the agency action [violates the APA], 'the practice of the court is ordinarily to vacate the rule.'" *Stewart I*, 313 F. Supp. 3d at 272 (quoting *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997)); *see also Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110 (D.C. Cir. 2014) ("[V]acatur is the normal remedy."); *Am. Great Lakes Ports Ass'n v. Schultz*, 962 F.3d 510, 512 (D.C. Cir. 2020) (remand without vacatur is an "exception[ ]" to the general rule).

Nothing about this case warrants a departure from the normal remedy of vacatur. *See Stewart I*, 313 F. Supp. 3d at 273-74. For remand without vacatur to be justified, the Court must consider "the seriousness of the deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed." *Allied-Signal, Inc. v. U.S. Nuclear Regul. Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993). Here, neither of those factors weighs against vacatur.

With respect to the first factor, courts "have not hesitated to vacate a rule when the agency has not responded to empirical data or to an argument inconsistent with its conclusion." *Comcast Corp. v. FCC*, 579 F.3d 1, 8 (D.C. Cir. 2009). "Failure to consider an important aspect of the problem is a major shortcoming generally warranting vacatur." *Stewart II*, 366 F. Supp. 3d at 155 (cleaned up). Among the major shortcomings here, the Secretary failed to reasonably consider whether HIP would promote the central purpose of the Medicaid Act, instead "turn[ing] [his] back on the implications" of the project. *Humane Soc'y of the U.S. v. Zinke*, 865 F.3d 585, 614-15 (D.C.

Cir. 2017). The deficiencies in the approval thus are serious and substantive, and it is unlikely that "the agency will be able to justify its decision on remand." *Long Island Power Auth. v. FERC*, 27 F.4th 705, 717 (D.C. Cir. 2022) (internal quotation marks and citation omitted). Moreover, where the Secretary has misinterpreted the statute, including the scope of his waiver authority, or "neglected to consider one of Medicaid's central objectives," "vacatur [is] appropriate." *Stewart I*, 313 F. Supp. 3d at 273; *see also Stewart II*, 366 F. Supp. 3d at 155-56; *Philbrick*, 397 F. Supp. 3d at 31-33 (summarizing grounds for vacatur in *Stewart I*, *Stewart II*, and *Gresham* and vacating approval).

As for the second factor—the disruptive consequences of vacatur—that consideration is "weighty only insofar as the agency may be able to rehabilitate its rationale for the regulation." *Comcast*, 579 F.3d at 9. For reasons Plaintiffs have described, the approval cannot be rehabilitated and, therefore, the Court need not reach the second factor. *See Standing Rock Sioux Tribe v. U.S. Army Corps of Eng'rs*, 282 F. Supp. 3d 91, 97 (D.D.C. 2017). But even if the Court were to consider this factor, it plainly weighs in favor of vacatur. Allowing the approval to remain in effect will disrupt access to health insurance coverage and medically necessary care for tens of thousands of Medicaid enrollees. *See Stewart II*, 366 F. Supp. 3d at 155 (noting that "the loss of Medicaid coverage is a substantial burden on Plaintiffs and others like them" and finding that vacatur would inflict less harm than the project). Conversely, the premiums and associated consequences for failure to pay have not been in effect in Indiana since March 2020, minimizing any disruptive consequences of vacatur to the State.

## CONCLUSION

For the reasons above, Plaintiffs respectfully ask the Court to vacate the 2020 and 2023 approvals.

Dated: March 20, 2024

Respectfully submitted,

/s/ Ian Heath Gershengorn
Ian Heath Gershengorn
Thomas J. Perrelli
Erica S. Turret
JENNER & BLOCK
1099 New York Ave., Suite 900
Washington, DC 20001
(202) 639-6869
tperrelli@jenner.com
igershengorn@jenner.com
eturret@jenner.com

*Counsel to National Health Law Program*

/s/ Jane Perkins
Jane Perkins
Catherine McKee
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
(919) 968-6308 (x101)
perkins@healthlaw.org
mckee@healthlaw.org

Adam Mueller
INDIANA JUSTICE PROJECT
1100 W 42nd St., Suite 200
Indianapolis, IN 46208
(317) 912-1135 ext. 800
amueller@injp.org

*Counsel for Plaintiffs*

# Exhibit A

**Declaration of Monte A. Rose, Jr.**

1. My name is Monte A. Rose, Jr. I am 52 years old and live alone in Bloomington, Indiana.
2. I graduated from high school and took some college courses.
3. In the past I was an attendant at a recycling facility, worked as a research assistant at Indiana University, and have been a reporter and columnist for local newspapers.
4. I do not currently have paid work or any income. I have been a part of starting a nonprofit devoted to producing educational journalism, providing affordable eco housing, creating green jobs, and growing organic medicinal foods. I hope to one day become self-employed as administrator of the nonprofit. We are working to secure funding for our operations. We have submitted a proposal to operate a health food pantry at a local low-income housing complex.
5. I receive a housing subsidy from the Bloomington Housing Authority to pay for my rent and I stretch my winter EAP utility assistance throughout the year by frugal use of electricity. I was previously made homeless for a period of four years.
6. I currently receive SNAP benefits. However due to a missed phone call, an annual interview was not completed. I rescheduled the interview, but the date given is two weeks past the cut off deadline. I am now in danger of losing these benefits and have been working diligently to submit all necessary redetermination documents.
7. I go to a local food pantry for food, and I eat organic vegetables that I grow myself as most processed foods set off an inflammation response, debilitating me mentally and physically.
8. I have never had a driver's license or a car. I ride a bicycle as my primary mode of transportation and for exercise. When medical appointments are too far to bike, I have

tried to use transportation services available through my health plan after a ride from a friend is cancelled. After receiving a tentative confirmation, the arranged transportation sometimes falls through on the day of the appointment, and as a result, I sometimes miss appointments, when not having money to hire a costly taxi.

9. I have Meniere's disease, an inner ear condition that periodically causes migraines, vertigo, nausea, and ringing in my ears. I applied for disability in 2008 but was denied.

10. In addition, since 2020 I have contended with Long COVID, experiencing a number of symptoms including cardiac symptoms, glandular swelling, vision problems, fatigue, anxiety, and depression. I have also recently been diagnosed with hypothyroidism and frozen shoulder, due to an overactive autoimmune response.

11. I have been unable to find paid work that will accommodate my health conditions or overlook a gap in my work history.

12. I am an unpaid caregiver for an elderly friend with mobility problems. This has included running errands and help with house cleaning and decluttering.

13. I have been enrolled in HIP since approximately 2018. Since that time, I have used my coverage to obtain new glasses and to receive dental care, which I had not been able to access previously. In addition, I have received vaccinations, diagnostic tests, and treatment for my chronic health conditions. I still have medical debt from before I enrolled in HIP for emergency room visits.

14. Recently I received an auto-renewal form for my health care. I confirmed that I am still eligible for HIP during a phone call with the Family and Social Services Administration, the state agency that administers my case.

15. Through my healthcare plan, I was recently assigned a new primary medical provider, a physician who is thankfully close to my home. Unfortunately, the new hospital and most diagnostic services that accept my form of insurance are not nearby.

16. If the POWER Account payments return, I believe I will be required to pay $1 per month. In the past, I have been able to rely on the kindness of others to help pay the premium. I do not know whether I will be able to get the money to pay these premiums in the future. I have not always received notices by mail in a timely manner.

I declare under penalty of perjury that the above information is true and correct.

3/15/24
Date

Monte A. Rose, Jr.

# Exhibit B

**Declaration of Chelsey Lang**

1. My name is Chesley Lang. I am 30 years old and live with my partner in Indianapolis, Indiana.
2. I am a first-generation college graduate and currently a 3rd year law student at the Indiana University Robert H. McKinney School of Law in Indianapolis. I am the Executive Managing Editor of the Health Law Review and have a note pending publication on lead contamination in housing in Northwest Indiana. I also participated in the Jeffrey G. Miller National Environmental Moot Court Competition.
3. After law school, I am undecided about future career plans but know that I want to practice law. I am interested in clerking, public interest, or some sort of practice that involves helping individuals navigate their legal issues.
4. Prior to law school, I spent five years teaching middle school science. I hope to use what I learn in law school to enrich the lives of others, as I did with the students I taught.
5. While a teacher, I used the employer-sponsored coverage offered through my job. When I left that job, I was briefly without any coverage, and during that time incurred medical expenses.
6. I enrolled in HIP in late 2021 or early 2022. I recall learning at that time that I would have a to pay a $20/month premium, but that due to the public health emergency, it was waived.
7. HIP has helped me to access primary care more regularly. When I was a teacher, we would change plans frequently which affected whether my providers were in network. As a result, I neglected my health care.

8. While on HIP, I have had the same managed care plan the whole time. This has allowed me to see the same doctors for regular check-ups.
9. Vision and dental coverage have also been very important to me. With vision coverage, I have been able to get my prescription updated. In terms of dental, I have been able to get routine cleanings. Last December I needed a root canal procedure and was able to have that performed.
10. Through HIP and having regular visits with primary care providers, I was able to receive genetic counseling related to a family history of cancer. With the information I had, I was able to encourage my mother to complete cancer screening. Without the regular primary care visits, this would not have happened. I was also recently able to have a mammogram as a result of this genetic counseling.
11. Toward the end of April 2023 and after responding to FSSA's request for additional documentation, I received a new one-year eligibility period for HIP.
12. In August of 2023, I was notified that my premium would be $1.00/month.
13. I had paid work in the fall of 2023 and attempted to report this income change through the online portal but am unclear if the report was successful. I made another report of income change through the online portal in December of 2023.
14. I have not received any notices or other information this year regarding my POWER Account or premiums. I believe they will be higher than $1.00 a month as I now have income. If I had to make a payment, I am not sure how to do so. If there was an error in my payment, I do not know how I would resolve it.
15. I am currently a law clerk at a private law firm, working 10-12 hours per week, on average, and making $17.00/hour. Due to the demands of law school, I am not able to

take on additional work. It will be difficult for me to afford the monthly POWER Account payment, as every month my expenses exceed my income.

I declare under penalty of perjury that the above information is true and correct.

3-18-24
Date

Chelsey Lang

# Exhibit C

**Declaration of Emily Rames**

1. My name is Emily Rames. I am 29 years old and live with my partner in Lafayette, Indiana.
2. I work at the reference desk of a public library, averaging 20-25 hours of work per week and earning $15.25 per hour. My gross income in 2023 was approximately $17,790.
3. I find this work rewarding, especially helping people find answers to their questions. I would like to be full-time; however, there are very few positions over 20 hours per week.
4. My partner and I pay monthly rent, utilities, internet, electricity, and food. I have student loan debt. Our household gets about $225/month in SNAP benefits.
5. I am currently driving a 1998 Toyota Corolla that I expect will break down soon.
6. I first applied for HIP in late 2022 or early 2023. Prior to that, I spent much of my adult life uninsured or using unaffordable employer-sponsored plans. When I was enrolled in employer-sponsored insurance, I incurred medical debt for emergency room charges that were sent to a collections agency. During times I was uninsured, I avoided seeking medical treatment because I feared medical debt.
7. HIP provides me with the opportunity to take care of my physical and mental health needs. It allows me the peace of mind that, despite my financial situation, I will have access to good health care if I need it. I plan to use HIP in the near future for vision care and primary care.
8. Recently I began waking up in a cold sweat each morning. Through my primary care doctor, I was able to have blood work testing done. When I contacted the testing facility to set an appointment, I was able to enter my HIP health plan information and schedule my appointment. The test results indicated that I may need further testing and treatment.

If it weren't for HIP, I would not have been able to seek and receive the initial testing. And, thanks to HIP, I will be able access any necessary treatments or medications that my doctor may prescribe for me.

9. If my car breaks down, I will have difficulty accessing appointments and would need assistance with non-emergency medical transportation.

10. In November or December of 2023, I received a notice informing me that I was approved for another year of HIP. I was also notified that I will have to pay a monthly premium, but that due to the public health emergency, that requirement is on hold.

11. To my knowledge, I have not received any notices this year that discuss any monthly premiums (or POWER Account Contributions).

12. I am confused about how the POWER Account payment process works. It is not clear to me where I would make the payment. And, if I had difficulty making the payment or if there was an error showing that I had not made a payment even though I had, I do not know how I would resolve this issue. I do not know if I would contact my health plan provider of the state agency that runs HIP.

13. Having to make a monthly payment will be a financial hardship for me. Given my income, if I do not pay the monthly premium, I will lose my Medicaid coverage. Loss of coverage would cause me a great deal of stress and anxiety.

14. HIP and health care really matter to me because my health matters to other people. There are people I care about who depend on me being alive and well in order to have their own needs met (partner, cat, community members). I am the only driver in my household, and because of where we live, my household and others are car dependent not only for our jobs, but for our pets' health, groceries, and connection to friends and family. Therefore,

it's very important to me to know that I am able to get preventative and/or life-saving care without fear of being turned away due to inability to pay.

I declare under penalty of perjury that the above information is true and correct.

3/13/2024
Date

Emily Ramos