IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, COMMONWEALTH OF MASSACHUSETTS, STATE OF NEW JERSEY, STATE OF ARIZONA, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, STATE OF ILLINOIS, STATE OF MAINE, STATE OF MARYLAND, PEOPLE OF THE STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEW MEXICO, STATE OF NEVADA, STATE OF NEW YORK, STATE OF OREGON, JOSH SHAPIRO, in his official capacity as Governor of the COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, STATE OF WASHINGTON, STATE OF WISCONSIN, *Plaintiffs*, *against* ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, MEHMET OZ, *in his official capacity as Administrator for the Centers for Medicare and Medicaid Services*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Defendants.*	Civil Action No. 1:25-cv-12019

[*PROPOSED*] BRIEF FOR AMICI CURIAE LOCAL GOVERNMENTS AND LOCAL PUBLIC HOSPITAL SYSTEMS IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION AND STAY

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INTERESTS OF AMICI

Amici are local public hospital and healthcare systems, and local governments that operate such systems. Together, we stand on the front lines of protecting the public health. Amici's views on public health are shaped by their deep and distinctive experience in the area. The City of New York, with more than eight million residents and tens of millions of annual visitors, has been at the forefront of public health for centuries. Today, through its Department of Health and Mental Hygiene, the City operates 10 no- or low-cost health clinics and a citywide school health program. NYC Health + Hospitals is the country's largest municipal hospital and healthcare system, serving more than 1.2 million people annually through 11 public hospital campuses, five post-acute/long-term care facilities, over 30 community-based healthcare centers, and more. Over 70% of NYC Health + Hospitals patients either rely on Medicaid or have no insurance.

The County of Santa Clara, which is the most populous of the San Francisco Bay Area's nine counties with roughly 1.9 million residents, operates the largest public health and hospital system in Northern California. Alongside its Public Health Department, Behavioral Health Services Department, Emergency Medical Services (EMS) Agency, Custody Health Department, and the County-run Valley Health Plan, the County also operates four public hospitals and a network of clinics that offer emergency, urgent, acute, preventative, and specialized care, as well as pharmacy services. The County's clinics and four public hospitals serve approximately 300,000 unique patients per year and serve as a critical health care safety-net provider, providing care to anyone in the County who needs it, regardless of financial circumstances, including indigent patients, patients who come from the 55%

of Santa Clara County households that do not speak English as a first language, and rural community members who would otherwise need to travel great distances to receive care.

King County, Washington, serves its 2.2 million residents with 15 public health centers. In addition, King County owns Harborview Medical Center, a world-renowned teaching hospital that is the only Level 1 trauma center serving Alaska, Idaho, Montana, and Washington. And the City and County of San Francisco, California, with roughly 800,000 residents, provides direct health services through its Department of Public Health to thousands of insured and uninsured people, including those most socially and medically vulnerable. It serves 125,000 people each year across its clinics and hospitals, including Zuckerberg San Francisco General, the only trauma center serving all of San Francisco and northern San Mateo County.

As safety-net healthcare providers, amici deliver essential medical and mental health services to people regardless of their ability to pay. Public healthcare facilities thus play a critical role in the nation's healthcare system by caring for uninsured and underinsured patients who have nowhere else to turn.

SUMMARY OF ARGUMENT

Local governments serve as the first line of defense in protecting the public health, and amici—which operate some of the nation's largest public hospital and healthcare systems—can report that these are particularly challenging times to do this work.

Providing high quality medical care in our communities has never been easy. But recent years have been particularly hard on public healthcare systems, which serve as safety-net providers that do not turn away patients, regardless of their

ability to pay. Across the country, safety-net hospitals are currently experiencing severe and unprecedented challenges because of the rising costs and demand for healthcare, severe staffing shortages, and insufficient revenue. These challenges have led to many hospital closures. And there is a snowball effect—as nearby hospitals and clinics close, remaining facilities must cover the spillover, and find their own uncompensated costs ballooning.

All of this can lead to overcrowding, longer wait times, and strained resources. That, in turn, erodes public trust in our public healthcare systems, further damaging public health, delaying diagnosis and treatment, contributing to the spread of infectious diseases, and causing healthcare costs to go up across the board.

The sweeping regulatory changes to eligibility and enrollment systems recently adopted by the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) will cause millions of individuals to lose healthcare insurance coverage. *See* Patient Protection and Affordable Care Act; Marketplace Integrity & Affordability, 90 Fed. Reg. 27,074 (June 25, 2025) (the "Final Rule"). Newly uninsured and underinsured patients will place enormous strain on safety-net providers, which must absorb the cost of care for individuals with nowhere else to turn.

Before the ACA was adopted, safety-net providers relied on an array of funding streams to defray the enormous costs of providing uncompensated and undercompensated care, but that framework is eroding as insurance coverage has expanded due to the ACA. The sudden increase in the number of newly uninsured individuals may put our nation's safety-net hospitals and healthcare systems on *worse*

footing than they were on before the ACA was adopted, at a time when they can ill afford to suffer such a blow.

Plaintiffs are likely to succeed on the merits because the extremely abbreviated time for notice and comment was legally insufficient, and because the Final Rule arbitrarily and unlawfully undermines, rather than advances, the aims of the ACA by, among other things, creating an unwarranted hurdle for potential enrollees by shortening open-enrollment periods, imposing unnecessary fees on enrollees, creating onerous and unjustified eligibility verification requirements on individuals seeking to purchase insurance, making it more difficult for individuals to verify their household income, allowing insurers to deny coverage to individuals with past-due premiums and to increase premiums, and reducing the scope of essential health benefits.

As local governments that operate large public hospitals and health systems and independent local public hospitals, amici know all too well the strain that these changes will place on safety-net providers and the ripple effect they will have on the broader public fisc and the public health. Given the immense public harms, the Final Rule should be preliminarily enjoined and stayed pending plaintiffs' litigation.

ARGUMENT

A. These are hard times to operate public healthcare systems and safety-net hospitals.

Public healthcare systems and hospitals provide crucial services across the nation. But they are facing unprecedented hurdles to delivering care.

Acute staffing and resource shortages have loomed for over a decade.[1] The Association of American Medical Colleges has projected a nationwide shortage of nearly 125,000 physicians in the next decade.[2] Staffing shortages force hospitals to reduce healthcare services, compounding hospitals' financial problems.[3]

The COVID-19 pandemic intensified these problems. Hospital staff worked in grueling conditions around the clock, logging significant overtime, to respond to an unprecedented disaster. They dealt with staggering patient mortality rates, full beds, and shortages of ventilators for patients and personal protective equipment for themselves—and experienced illness, burnout, exhaustion, and trauma.[4]

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[1] Daily Briefing: *America deliberately limited its physician supply—now it's facing a shortage*, ADVISORY BD. (Feb. 16, 2022), https://perma.cc/5XJK-U887; Carmichael, Mary, *Primary-Care Doctor Shortage Hurts Our Health*, NEWSWEEK (Feb. 25, 2010), https://perma.cc/2UUS-NSK3.

[2] *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034,* ASS'N OF AM. MED. COLL. (June 2021), https://perma.cc/3WD7-5ACY; Robezneiks, Andis, *Doctor shortages are here—and they'll get worse if we don't act fast,* AM. MED. ASS'N (Apr. 13, 2022), https://perma.cc/BP8M-3T8P.

[3] Muoio, Dave, *'Unsustainable' losses are forcing hospitals to make 'heart-wrenching' cuts and closures, leaders warn*, FIERCE HEALTHCARE (Sept. 16, 2022), https://perma.cc/MSD2-E5UH (reporting that, due to shortage of 3,900 nurses and 14% of clinical support staff, Trinity Health, which operates 88 hospitals, has had to take 12% of its beds, 5% of operating rooms, and 13% of emergency departments offline); Glatter, Dr. Robert, et ano., *The Coming Collapse of the U.S. Health Care System*, TIME (Jan. 10, 2023), https://perma.cc/3CXV-DEBP (explaining that hospital beds are "browned out" due to lack of staff, leading to overcrowding).

[4] Pearson, Bradford, *Nurses Are Burned Out. Can Hospitals Change in Time to Keep Them?* N.Y. TIMES (Feb. 20, 2023), https://tinyurl.com/y2c37dxt; Belluz, Julia, *The doctors are not all right,* VOX (Jun. 23, 2021), https://perma.cc/9JB2-4N26.

Pandemic-related challenges triggered a mass exodus from the medical profession.[5] The outlook for hospitals has remained bleak even as the pandemic has receded.[6]

Add to all this an aging population, and demand for medical care is at an all-time high just as the supply is plummeting. Never before have so many people lived so long. All of the nation's 74 million baby boomers will soon be 65 or older; and by 2035 seniors will outnumber children.[7] "[O]lder people see a physician at three or four times the rate of younger people and account for a highly disproportionate number of surgeries, diagnostic tests, and other medical procedures."[8] And this aging population includes physicians and nurses themselves. "We're facing a physician retirement cliff"—with many actively licensed physicians age 60 or older, and not enough new doctors taking their places.[9]

The challenges facing public hospitals, as compared with private hospitals, are deepened by the demographics of public hospitals' patient populations. Even with the gains in insurance coverage occasioned by the ACA, over 200,000 of the

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[5] *Issue Brief: Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, U.S. DEP'T OF HEALTH AND HUMAN SERV., (May 3, 2022), https://perma.cc/U6VA-XJ2M.

[6] *Early NFP Hospital Medians Show Expected Deterioration; Will Worsen*, FITCH (Mar. 2, 2023), https://perma.cc/PB8W-9N6K; *see e.g.*¸ Adcroft, Patrick, *Mount Sinai Beth Israel hospital to close amid financial losses,* NY1 (Sep. 14, 2023), https://perma.cc/F9G9-M35P; Dyrda, Laura, *293 Hospitals At Immediate Risk Of Closure*, BECKER HOSPITAL REVIEW (June 2, 2023), https://perma.cc/MHT2-85ZV; Zhang, Xiaoming, et al., *Physician workforce in the United States of America: forecasting nationwide shortages*. HUM RESOUR. HEALTH (Feb. 6, 2020), https://perma.cc/8BQV-4TMW.

[7] Howley, Elaine, *The U.S. Physician Shortage Is Only Going to Get Worse. Here Are Potential Solutions,* TIME (Jul. 25, 2022), https://perma.cc/6MNC-FDCB.

[8] *Id.*

[9] *Id.*

patients New York City's public healthcare system serves every year are uninsured, and most other patients are insured by public payers that reimburse providers at below-cost rates, resulting in more than $1 billion in uncompensated care.[10] Likewise, of the 300,000 patients served by the County of Santa Clara's public hospitals and clinics every year, approximately 16,000 are uninsured, 170,000 are insured by Medi-Cal (California's implementation of the federal Medicaid health care program), and 32,000 are insured by Medicare.

Providing medical care for uninsured and underinsured populations is already challenging for a number of reasons. Low-income individuals have historically suffered from a range of acute ailments at higher rates than their higher-income counterparts.[11] The communities served by public hospitals are disproportionately susceptible to "chronic conditions, such as hypertension and diabetes, that are by far the largest drain on our health system."[12]

Moreover, uninsured individuals forgo preventative care and routine screenings at higher rates than their insured counterparts.[13] As a consequence, safety-net

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[10] *Metropolitan Anchor Hospital (MAH) Case Study, NYC Health + Hospitals | New York*, AM. HOSPITAL ASS'N (June 2022), https://perma.cc/6Q6P-QR8U; *Fact Sheet: Underpayment by Medicare and Medicaid*, AM. HOSPITAL ASS'N (Feb. 2022), https://perma.cc/6D5D-A3M5.

[11] Madara, Dr. James, *America's health care crisis is much deeper than COVID-19,* AM. MED. ASS'N (Jul. 22, 2020), https://perma.cc/KD4L-P6MU.

[12] *Id.*

[13] *Nearly a Quarter of People Who Say They Were Disenrolled from Medicaid During the Unwinding Are Now Uninsured* (April 24, 2024), KFF, https://perma.cc/PPU6-Z5G8 (reporting that the majority of individuals who lost their health insurance skipped or delayed care or prescriptions); *Facilitating Equitable Access to Cancer Screening – President's Cancer Panel*, U.S. DEP'T OF HEALTH AND HUMAN SRVS. NAT'L CANCER INST. (Feb. 2, 2022), https://perma.cc/R6KD-BX5C (same, for cancer screenings); Lu, P.J., et al, *Impact of Health Insurance Status on*

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hospitals become default clinics, even for non-emergencies. And delays in diagnosis and treatment also lead to negative medical outcomes and higher costs in providing emergency medical care for avoidable ailments.[14]

Safety-net hospitals and clinics have faced a perfect storm. The massive shortfall of staff and resources, coupled with increased demand for uncompensated care, already creates acute financial pressures.[15] Since 2010, an astounding number of hospitals—more than 150—across the country have closed,[16] and more than 600 are at risk of closure.[17] This includes both rural and inner-city hospitals, and has put significant strain on surviving hospitals.[18] For example, earlier this year the County of Santa Clara purchased Regional Medical Center (RMC), a then-private hospital that was progressively eliminating services, such as labor and delivery, and then

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Vaccination Coverage Among Adult Populations, AM. J. PREV. MED., 2015;48(6):647-661(June 2015), https://www.ajpmonline.org/article/S0749-3797(14)00719-3/pdf.

[14] Bermudez, D., & Baker, L. C. (2005). *The Relationship between SCHIP Enrollment and Hospitalizations for Ambulatory Care Sensitive Conditions in California*. J HEALTH CARE POOR UNDERSERVED, 16(1), 96-110; Garfield, R., et al., *The Uninsured and the ACA: A Primer-Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act*. KFF (Jan. 25, 2019), https://perma.cc/W4TN-WFAD; Starfield, B. and Shi Leiyu J., *Contribution of Primary Care to Health Systems and Health*, MILBANK Q (Oct. 3, 2005), https://perma.cc/JFX8-5HV7.

[15] *The Current State of Hospital Finances: Hospital Finance Report, Fall 2022 Update*, KAUFMAN HALL, https://perma.cc/327Z-3CHP.

[16] Map: *Rural Hospital Closures 2005-Present*, UNC CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH (launched 2014), https://perma.cc/64VH-ZWF4.

[17] Severance, H., *More Hospitals Are Closing. Why?* ACEP NOW (Jan.11, 2024), https://perma.cc/CAS4-Z6HH; Weissart, D., *The Toll of Rural Hospital Closures*, BOSTON U. SCHOOL OF PUBLIC HEALTH, PUBLIC HEALTH POST (June 18, 2024), https://perma.cc/YVA6-4XUV.

[18] Rau, Jordan, *Urban Hospitals of Last Resort Cling to Life in Time of COVID*, KHN (Sept. 17, 2020), https://perma.cc/5VRQ-MQTV.

trauma care, and that serves a community of residents who are nearly twice as likely to lack health insurance compared with County residents overall. Indeed, about 40% of the County's Medicaid enrollees live within five miles of RMC. Many other hospitals and clinics have survived only by shutting down select vital services. "It is not uncommon to hear that health care systems have shut down Pediatrics, Psychiatry, Obstetrics, and ICU."[19] And inpatient beds and operating rooms taken offline due to staffing shortages lead to longer wait times for admission from emergency rooms. The problem is compounded by corresponding shortages in outpatient and rehabilitation facilities, which delay patient discharge.[20] In all, even before the Final Rule, the challenges of operating public hospitals and healthcare systems were profound.

B. Public health suffers when safety-net hospitals face dramatic increases in uninsured patients.

The Final Rule will push these problems past the breaking point, putting a dramatic unnecessary strain on limited resources and causing delays in treatment or reductions in services for an array of conditions. When public confidence in the ability of public healthcare systems to provide quality services erodes, harms reverberate across our communities.

As explained above, there is already a scarcity of resources causing the closure of hospitals, shuttering of departments, and delays in services. Thousands of patients, regardless of their insurance status, in need of all kinds of medical care, could find themselves facing significant delays, and some may forgo care altogether, as health system resources are stretched to address the acute needs of newly

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[19] Glatter, *supra* n.3.

[20] *Id.*

uninsured populations who spillover from non-safety-net healthcare providers. These negative experiences have significant, community-wide impacts.

Research shows that patients who have negative medical experiences, or who feel betrayed by their medical institutions—for example, an individual whose much-needed surgery is delayed due to lack of space in the operating room—are more likely to distrust and disengage from their healthcare providers.[21] Negative experiences make people less likely to follow medical advice in the future. And loss of faith in healthcare providers reaches beyond the individual: research also shows that people who feel that a relative has experienced poor medical care are likely to lose trust in healthcare providers in general.[22]

These ripple effects carry far beyond one individual's experience, and result in increased public skepticism of medical providers, which correlates with devastating consequences for local governments' ability to ensure their communities' health and welfare. For instance, research shows that individuals who mistrust healthcare systems are also more likely to delay seeking health care, fail to adhere to medical advice, and miss medical appointments.[23] Unsurprisingly, these tendencies can lead to worse individual health outcomes.

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[21] Smith, Carly Parnitzke, *First, do no harm: institutional betrayal and trust in health care organizations*, 10 J. MULTIDISC. HEALTHCARE 133, 137, 140-42 (2017), https://perma.cc/4F93-3MK5.

[22] Oguro, Nao, et al., *The impact that family members' health care experiences have on patients' trust in physicians*, BMC HEALTH SERV. RSCH., at 2, 9-10 (Oct. 19, 2021), https://perma.cc/AA8E-LPU4.

[23] LaVeist, Thomas A., et al., *Mistrust of Health Care Organizations is Associated with Underutilization of Health Services*, 44 HEALTH SERVS. RSCH., 2093, 2102-03 (2009), https://perma.cc/A3GV-PNZW.

What's more, when large numbers of individuals in our communities delay seeking care and miss out on early diagnosis and treatment of emerging diseases, it impairs the ability of our public health officials to quickly detect outbreaks of communicable diseases. Delays prevent officials from rapidly responding to contain outbreaks, leading to the spread of illnesses across our communities and placing yet more strain on our fragile public health systems.[24] Thus, reduced trust in healthcare professionals and systems will impair local governments' ability to carry out one of their core functions: ensuring the safety and wellbeing of their residents.[25]

C. The enormous costs of the Final Rule will be carried by public healthcare systems and safety-net hospitals.

Public hospitals and healthcare systems will feel the fiscal strain caused by the Final Rule acutely. As explained above, safety-net providers will, of course, have to shoulder the dramatically increased costs for uncompensated care for uninsured and underinsured patients. And patients from private hospitals and clinics whose care is no longer covered will spill over onto safety-net providers, further increasing uncompensated care costs. The financial strain will only be amplified by the fact that uninsured and underinsured patients who forgo preventative care and screenings may experience avoidable, high-cost hospital stays.

And there is reason to believe that increasing the number of uninsured individuals will put public hospitals and healthcare systems in a worse position than

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[24] *Communicable diseases and primary health care: the way forward*, who-uhl-technical-brief-communicablediseases.pdf

[25] *See, e.g.*, Blewett, L., et al., *Aligning US Health and Immigration Policy to Reduce the Incidence of Tuberculosis.*, 18(4) INT J TUBERC. LUNG DISEASE, 397-404 (April 18, 2024), https://perma.cc/NWF5-DB9V.

they were in before the ACA was adopted. In 2013, before the ACA was adopted, the uncompensated costs of care for uninsured individuals totaled roughly $85 billion, and safety-net hospitals relied on a number of sources to defray these costs.[26] Safety-net hospitals could not offset their uncompensated costs because of a low percentage of commercially insured patients. Instead, they relied on programs, such as the federal Disproportionate Share Hospital (DSH) program, which provides federal funds to safety-net hospitals that serve a high proportion of Medicaid beneficiaries and uninsured patients.[27]

Since 2014, when the ACA was fully implemented, there has been a significant reduction in the number of uninsured individuals nationwide—falling from 14.5% in 2013 to 9.4% in 2015 (a 35% decline)—down to 8% last year.[28] This increase in the rate of individuals with health insurance, in turn, drove a steep decline in unpaid hospital bills. For example, the share of nonelderly individuals incurring uncompensated care costs fell from 7.3% in 2011–2013 to 4.8% in 2015–2017—a drop of more than one-third.[29] In that same time, the aggregate annual cost of uncompensated care fell from an average of roughly $63 billion per year to roughly

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[26] Garfield, *supra* n.14.

[27] *GHYHA Position Paper: Medicaid DSH* (Sept. 9, 2024), https://perma.cc/CKE2-DX7F.

[28] Schubel, J. and Broaddus, M, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains*, CENTER ON BUDGET & POLICY PRIORITIES (May 23, 2018), https://perma.cc/25ZK-4W5Z; *Health Insurance Coverage in the United States: 2023*, US CENSUS BUREAU (Sept. 10, 2024), https://perma.cc/QC28-5GG8.

[29] Karpman, M., et al., Declines in Uncompensated Care Costs for The Uninsured under the ACA and Implications of Recent Growth in the Uninsured Rate, KFF (April 6, 2021), https://perma.cc/8RQ9-5ZBP.

$42 billion.[30] As a result, hospitals' uncompensated care costs as a share of operating expenses fell by about 30%, translating to $12 billion nationwide in 2015.[31]

Though the increase in the insured population was an unprecedented public health achievement, Congress responded to the uptick in rates of health insurance by making cuts to the DSH program.[32] Those cuts are now looming. As a result, safety-net hospitals may be in a worse position to absorb increases in uncompensated costs than they were before the ACA.

In sum, public healthcare systems and hospitals will be rocked by the Final Rule at a time when steep staffing shortages, as well as soaring demand and costs, are already causing widespread hospital closures. The Final Rule will undermine the ability of local governments to protect public health with devastating consequences across the board. When low-income individuals lose affordable coverage, their medical costs will not simply disappear, as HHS and CMS seem to have assumed; they will be shifted onto the backs of our safety-net hospitals and public healthcare systems, many times amplified. And some safety-net providers will surely buckle under the weight.

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[30] *Id.*

[31] Schubel, *supra* n.28.

[32] *Id.*; *Medicaid Disproportionate Share Hospital (DSH) Payments*, MEDICAID.GOV, last accessed on Aug. 5, 2025 at https://www.medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments; Hut, N., *Medicaid DSH payment cut again delayed in proposed funding bill*, HFMA (March 11, 2025), https://perma.cc/TX7L-BBLU.

CONCLUSION

This Court should grant the plaintiffs' motion for a preliminary injunction and stay.

Dated: New York, New York
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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that this motion and its accompanying certification will be served on all registered parties through this Court's CM/ECF system.

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