No. 17-3029

In the United States Court of Appeals for the Eighth Circuit

MICHAEL POSTAWKO, *et al.*,

Plaintiffs-Appellees,

v.

MISSOURI DEPARTMENT OF CORRECTIONS, *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Missouri, No. 2:16-cv-04219-NKL
The Honorable Nanette K. Laughrey, U.S. District Judge

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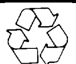

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INTEREST OF AMICI CURIAE

The Lawyers' Committee for Civil Rights Under Law (the "Lawyers' Committee") is a nonpartisan, nonprofit organization, formed in 1963 at the request of President John F. Kennedy to enlist the private bar's leadership and resources in combating racial discrimination and the resulting inequality of opportunity. The Lawyers' Committee's principal mission is to secure equal justice for all through the rule of law, targeting in particular the inequities confronting African Americans and other racial and ethnic minorities. The Lawyers' Committee has a particular interest in this case because African Americans and other minorities make up a disproportionate percentage of the persons suffering from chronic hepatitis C and are thus disproportionately impacted by Defendants' policies.[1]

BACKGROUND AND SUMMARY OF ARGUMENT

This action is one of the growing number of cases raising the issue of whether prisoners with chronic hepatitis C who are denied treatment as a consequence of an institutional policy may properly be certified as a class.[2] It is

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[1] Pursuant to Fed. R. App. P. 29(a)(4), all parties have consented to this brief's filing. No party's counsel authored this brief in whole or in part. No party or party's counsel, or any other person, other than the *amicus curiae* or its counsel, contributed money that was intended to fund the preparation or submission of this brief.

[2] *See Ligons et al.* v. *Minn. Dep't of Corr. et al.*, Case No. 15-cv-02210-PJS-BRT (D. Minn. filed May 1, 2015); *Fowler* v. *Turco*, Case No. 1:15-cv-12298-NMG (D.

the first to reach a court of appeals. This recent increase in such cases is not a coincidence—rather, it is the direct result of recent revolutionary advances in the treatment of the hepatitis C virus (HCV). The discovery of new, remarkably effective direct acting antiviral (DAA) drugs has led not only to positive changes in medical outcomes that were previously impossible to achieve, but also to changes in treatment guidelines and health care policies and practices. Since the revolutionary introduction of DAA drugs, standard-of-care guidelines have shifted, Medicaid providers have expanded their treatment coverage, prison systems have altered their policies, foreign governments have instituted programs to cure the disease, and as here, parties have begun challenging outmoded treatment policies and practices through litigation.

The sea-change in HCV treatment is transforming the applicable standard of care and access to HCV treatment. The sweeping nature of these widely recognized treatment advances underscores that Defendants' failure to provide such treatment to any but a handful of prisoners can be explained only as being the

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Mass. filed June 10, 2015); *Chimenti et al.* v. *Penn. Dep't of Corr. et al.*, Case No. 2:15-cv-03333-JP (E.D. Pa. filed June 12, 2015); *Graham* v. *Parker*, Case No. 3-16-cv-01954 (M.D. Tenn. filed July 25, 2016); *Hoffer* v. *Jones*, Case No. 4:17-cv-00214-MW-CAS (N.D. Fla. filed May 11, 2017); *Aragon* v. *Raemisch*, Case No. 1:17-cv-01744-RBJ (D. Colo. filed July 19, 2017); *Riggleman* v. *Clarke et al*, Case No. 5:17-cv-00063-NKM-JCH (W.D. Va. filed June 26, 2017).

result of a system-wide policy to avoid providing such treatment, making it appropriate to be challenged on a classwide basis.

Background on Hepatitis C. Hepatitis C is a contagious liver disease resulting from HCV infection that has devastating effects on its patient population. For every 100 persons infected with HCV, approximately 75 to 85 develop chronic hepatitis C, a long-term illness that can lead to serious liver problems including cirrhosis (scarring of the liver) or liver cancer.[3] Out of that same 100 persons, 60 to 70 will develop chronic liver disease, 5 to 20 will develop cirrhosis, and 1 to 5 will die from the consequences of chronic infection (liver cancer or cirrhosis).[4]

An estimated 2.7 to 3.9 million people in the United States have chronic hepatitis C, and the Centers for Disease Control and Prevention (CDC) estimates that, in 2014, there were 19,659 deaths with HCV as an underlying or contributing cause.[5] In May 2016, the CDC reported that hepatitis C kills more Americans than any other infectious disease, including HIV.[6] Chronic hepatitis C disproportionately affects incarcerated individuals, with conservative research

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[3] CDC, *Hepatitis C FAQs for the Public*, https://www.cdc.gov/hepatitis/hcv/cfaq.htm (last visited Feb. 6, 2018).

[4] CDC, *Hepatitis C FAQs for Health Professionals*, https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm (last visited Feb. 6, 2018).

[5] *Id.*

[6] CDC, *Hepatitis C Mortality*, https://www.cdc.gov/nchhstp/newsroom/2016/hcv-mortality.html (last visited Feb. 6, 2018).

estimating that hepatitis C is seven times more prevalent among prisoners than in the general population.[7] It also disproportionately impacts African Americans who comprise approximately 11% of the U.S. population but represent 25% of the people with chronic HCV infections.[8]

ARGUMENT

I. RECENT DRUG ADVANCEMENTS HAVE REVOLUTIONIZED HEPATITIS C TREATMENT, BUT ALMOST NONE OF MISSOURI'S PRISONERS WITH HEPATITIS C RECEIVE SUCH TREATMENT

Defendants argue that Plaintiffs failed to established commonality because the members of the class have disparate treatment needs. (Appellants' Br. at 19–26.) This is an incorrect framing of the common question, which should be whether all class members are exposed to a uniform policy or practice that creates substantial risk of serious harm. (*See* Appellees' Br. at 26–42.) Here, they are. With the recent introduction of DAA drugs, there has been a sea-change in HCV treatment. These revolutionary medicines have led to a new standard of care and evolving practices in Medicaid, foreign governments, and correctional facilities in

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[7] Pew Charitable Trusts, *State Prison Health Care Spending* at 9 (July 2014), http://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf.

[8] Corinna Dan, *Hepatitis C Disparities among African Americans*, U.S. Dept. of Health & Human Serv. (Feb. 27, 2017), https://www.hhs.gov/hepatitis/blog/2017/02/27/hepatitis-c-disparities-among-african-americans.html.

other jurisdictions. The near-blanket failure to provide such treatment in Missouri's prisons can be explained only as being the result of a systemwide policy by Defendants that is appropriately remedied on a classwide basis.

A. The Introduction of New DAA Drugs Revolutionized HCV Treatment

Prior to 2013, HCV treatment required "grueling shots" lasting six months to a year and "pills that gave patients flu-like symptoms and still barely cured half of them."[9] This all changed beginning in December 2013 when FDA approved Gilead's Sovaldi, a DAA that marked the "advent of interferon-free treatments for hepatitis C" and "a landmark shift in the treatment of hepatitis C."[10] Since December 2013, FDA has approved eight additional drugs to treat hepatitis C. FDA calls these advances in HCV treatment "transformative."[11] Prior interferon-based injection treatments lasted six months to a year, often made patients ill and gave them flulike symptoms, and cured only 40% to 50% of patients who were

[9] Associated Press, *FDA approves new drug to treat hepatitis C*, (Aug. 4, 2017), https://www.cbsnews.com/news/fda-approves-mavyret-abbvie-drug-to-treat-hepatitis-c/.

[10] Richard Knox, *Treatments: FDA Expected To Approve New, Gentler Cure For Hepatitis C*, NPR (Dec. 5, 2013), https://www.npr.org/sections/health-shots/2013/12/05/248934833/fda-set-to-approve-hepatitis-drug.

[11] FDA, *Hepatitis C Treatments Give Patients More Options*, https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm405642.htm (last updated May 4, 2017).

treated.[12] New DAA drugs "double[d] the viral cure rates—90% to 100%—in just in 12 weeks' time."[13] And the treatment landscape continues to improve and change. One journal article speculates that we may eventually see single-tablet regimens lasting no more than 4 to 6 weeks.[14] The Infectious Diseases Society of America (IDSA) and American Association for the Study of Liver Diseases (AASLD) provide continually updated guidance for HCV treatment with the stated goal "to provide up-to-date recommendations to healthcare practitioners" in part because of "the rapid evolution of highly effective antiviral therapy for HCV infection."[15]

B. The Standard of Care is that Nearly All Chronic HCV Patients Should be Treated

With the introduction of DAA drugs, the standard of care for HCV patients is that nearly all patients with chronic HCV infection should be treated. This standard is supported by the IDSA/AASLD Guidelines. The CDC refers health professionals to the IDSA/AASLD guidelines as "evidence-based, expert-

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[12] *Id.*

[13] *Id.*

[14] Brian P. Lam et al., *The changing landscape of hepatitis C virus therapy: focus on interferon-free treatment*, Therap. Adv. Gastroenterol 8(5): 298-312 (Sept. 2015), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4530432/.

[15] AASLD/IDSA, HCV Guidance, *Table 1. Summary of the Process and Methods for the Guidance Development*, https://www.hcvguidelines.org/contents/methods/table-1 (last updated Sept. 21, 2017).

developed recommendations for hepatitis C management."[16] The guidelines are a "credible source of unbiased guidance on how best to treat [healthcare practitioners'] patients with HCV infection."[17] They provide "timely guidance" as "new information is presented at scientific conferences and published in peer-reviewed journals."[18]

The guidelines "recommend treatment for nearly all patients with chronic HCV infection."[19] Specifically, they state: "Successful hepatitis C treatment results in sustained virologic response (SVR), which is tantamount to virologic cure and, as such, is expected to benefit nearly all chronically infected persons."[20] They add that "from a medical standpoint, data continue to accumulate that demonstrate the many benefits, both intrahepatic and extrahepatic, that accompany HCV eradication. Therefore, the panel continues to recommend treatment for all patients with chronic HCV infection, except those with a short life expectancy that

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[16] CDC, *Hepatitis C FAQs for Health Professionals*, https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm (last visited Feb. 6, 2018).

[17] AASLD/IDSA, HCV Guidance, *About the Guidance*, https://www.hcvguidelines.org/about.

[18] *Id.*

[19] U.S. Dept. of Health & Human Serv., *National Viral Hepatitis Action Plan 2017-2020* at 24 (Jan. 2017), *available at* https://www.hhs.gov/sites/default/files/National%20Viral%20Hepatitis%20Action%20Plan%202017-2020.pdf (emphasis added).

[20] AASLD/IDSA, HCV Guidance, *When and in Whom to Initiate HCV Therapy*, https://www.hcvguidelines.org/evaluate/when-whom (last updated Sept. 21, 2017) (emphasis added).

cannot be remediated by HCV treatment, liver transplantation, or another directed therapy."[21] With regard to testing, the IDSA/AASLD guidelines recommend periodic testing to "persons with ongoing risk factors for HCV exposure," and one risk exposure is incarceration.[22]

With a revolutionary shift in available medicines and a standard of care that nearly all chronic HCV patients should be treated, health care coverage, policies, and practices have also started to transform in different areas:

Medicaid Providers. Medicaid providers have been expanding DAA drug treatment coverage. On May 27, 2016, a district court ordered Washington Medicaid to lift restrictions on providing HCV medicines.[23] On June 3, 2016, Delaware's Division of Medicaid and Medical Assistance revoked categorical cover exclusions of HCV cures (providing cures only to those whose disease had progressed to the point of significant liver damage of cirrhosis).[24] In June 2016,

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[21] *Id.* (emphasis added).

[22] *See* AASLD/IDSA, HCV Guidance, *HCV Testing and Linkage to Care*, https://www.hcvguidelines.org/evaluate/testing-and-linkage (last updated Sept. 21, 2017).

[23] *See B.E.* v. *Teeter*, Case No. C16-227-JCC, 2016 WL 3033500, at *6 (W.D. Wash. May 27, 2016).

[24] Center for Health Law & Policy Innovation: Harvard Law School, *In Face of Class Action Lawsuit, Delaware Medicaid Removes Unlawful Restrictions to the Cure for the Hepatitis C Virus* (June 8, 2016), https://www.chlpi.org/in-face-of-class-action-lawsuit-delaware-medicaid-removes-unlawful-restrictions-to-the-cure-for-the-hepatitis-c-virus/.

Florida Medicaid also changed the state's Medicaid policy to require insurance companies to provide HCV drugs at an earlier stage in the disease.[25]

Foreign Governments. The World Health Organization (WHO) reported that because new DAAs are much safer and produce high cure rates, "eligibility criteria are becoming more liberal and some countries are expanding their HCV treatment programmes so that they can treat virtually all people with HCV infection and 'eliminate' HCV in their populations."[26] Separately, Egypt, having "one of the world's highest incidence rates of hepatitis C—about 7 percent of its 90m population," began an aggressive program to eliminate hepatitis C using DAA drugs and has treated nearly 1 million hepatitis C patients in two years.[27] One study found that the use of DAAs in Egypt led to HCV viral suppression in nearly all treated patients,[28] and experts say Egypt could be the model for the rest of the world.[29]

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[25] Associated Press, *Florida Changes Hep C Drug Policy for Medicaid*, (June 1, 2016), https://www.nbcmiami.com/news/local/Florida-Changes-Hep-C-Drug-Policy-for-Medicaid-381573511.html.

[26] WHO, Guidelines for the screening, care and treatment of persons with chronic hepatitis C infection at 100 (April 2016), *available at* http://www.who.int/hepatitis/publications/hepatitis-c-guidelines-2016/en/.

[27] Heba Saleh, *Egypt combats hepatitis C epidemic with state-run scheme*, Financial Times (Jan. 22, 2017), https://www.ft.com/content/d1e18e96-d81b-11e6-944b-e7eb37a6aa8e.

[28] *See* Ahmed Nagaty, *Real-life results of sofosbuvir based therapy in chronic hepatitis C -naïve and experienced patients in Egypt*, PLOS One (Oct. 5, 2017),

Prisons. Just as certain Medicaid providers and foreign governments are changing their hepatitis C treatment policies, some correctional systems have also started adapting to providing new HCV treatment. The New York Department of Corrections increased its spending on prescription drugs from fiscal 2013–2015, which state officials attribute mostly to purchases of new hepatitis C medications.[30] New York has treated more than 600 inmates with DAAs.[31] In May 2017, "[b]ecause of advances in medicine," Wisconsin treated "more than 200 inmates" with DAAs in less than a year.[32] Wisconsin's Department of Corrections officials indicated that the state increased the number of inmates receiving treatment for HCV from 72 in 2016 to 249 through spring 2017 because "pills with higher success rates and fewer side effects landed on the market and medical

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http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0184654 (finding an overall sustained virological response rate of 97.1%).

[29] Saleh, *Egypt combats hepatitis C epidemic with state-run scheme*, *supra* note 27.

[30] Pew Charitable Trusts, Prison Health Care: Costs and Quality at 16 (Oct. 2017), http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.

[31] Beth Schwartzapfel, Prisons are spending millions on a pricey new drug, Business Insider (Oct. 14, 2016) http://www.businessinsider.com/prisons-are-spending-millions-on-a-pricey-new-drug-2016-10.

[32] Keegan Kyle, *Wisconsin prisons spend $10M treating hepatitis C*, Post Crescent (May 25, 2017), http://www.postcrescent.com/story/news/investigations/2017/05/25/wisconsin-prisons-spend-10m-treating-hepatitis-c/99007788/.

professionals shifted their recommendations to promote earlier treatment."[33] Where prison systems fail to meet the standard of care, parties are bringing class action lawsuits. In Tennessee, for-profit medical provider Centurion treated only 8 out of 3,487 prisoners known to be infected with HCV with DAAs as of May 2016, and prisoners sued.[34] In Massachusetts, Centurion treated only 3 out of 1,500 state prisoners known to be infected with HCV in 2015, and prisoners sued.[35] And here, in Missouri, Corizon treated only 5 out of 4,736 prisoners known to be infected with HCV as of January 2015, and Plaintiffs sued.[36]

The introduction of revolutionary DAA drugs has created a new standard of care and is starting to transform policies and practices broadly across different areas. It has transformed eradication of the disease in our prisons—and in society as a whole—from a distant dream to an attainable reality. Defendants' extremely low treatment rate can be explained only as being the result of a systematic policy

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[33] *Id.*

[34] PR Newswire, Centurion Selected To Provide Correctional Healthcare In Tennessee (June 11, 2013), https://www.prnewswire.com/news-releases/centurion-selected-to-provide-correctional-healthcare-in-tennessee-210981341.html; Class Action Compl. ¶ 19, *Graham* v. *Parker*, Case No. 3-16-cv-01954, Dkt. No. 1 (M.D. Tenn. filed July 25, 2016).

[35] Class Action Compl. ¶¶ 1, 67, *Fowler* v. *Turco*, Case No. 1:15-cv-12298-NMG, Dkt. No. 1, (D. Mass. filed June 10, 2015) (3 out of 1,500 treated); *id.* ¶ 9 (bringing the action against Massachusetts Partnership for Correctional HealthCare, LLC, a subsidiary of Centurion, LLC).

[36] Second Am. Compl. ¶ 51, Dkt. No. 30.

of avoiding these revolutionary new treatments. There is simply no other credible explanation. Thus, Plaintiffs' challenge should be considered on a classwide basis.

II. CORIZON, MISSOURI'S PRISON HEALTHCARE PROVIDER, IS SINGLE-MINDEDLY FOCUSED ON COSTS

It appears to be no accident that Defendants' policies and practices are driven by Missouri's for-profit provider, Corizon. As a private, for-profit company, Corizon is "acutely aware of costs."[37] Corizon typically enters "full risk" contracts with state corrections systems, by which Corizon receives a predetermined monetary amount, regardless of the extent to which Corizon's on-site services or other, off-site medical services are utilized.[38] This suggests that, unlike other businesses, cost reduction for Corizon does not mean a simple decrease in operating expenses; cost-cutting for Corizon corresponds one-for-one with a reduction in needed care. Under this model, the less treatment inmates receive, the greater the profit realized by Corizon.[39]

As a matter of business policy, Corizon spends "significantly less" on treatment for incarcerated individuals than the general population spends per

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[37] Corizon "Provider Info Manual," *available at Norwood* v. *Thomas*, Case No. 5:14-cv-00430-CLS (N.D. Al.), Plaintiff's Ex. 3, Dkt. No. 51-3, at 3, (Oct. 23, 2015).

[38] *Norwood* v. *Thomas*, Case No. 5:14-cv-00430-CLS, 2016 WL 192062 at *9, (N.D. Al. Jan. 15, 2016) (quoting deposition of Corizon Regional Director Dr. Hugh Hood).

[39] *See id*.

person on medical care.[40] Corizon does not shy away from this comparison. To the contrary, former CEO Rich Hallworth advertises: "We are the model because we've been doing capitated rates since we've been in business."[41] Unfortunately, there is a correlation between these rates and Corizon's quality of treatment. In fact, experts have testified that Corizon's cost-centric model renders it "incapable of recognizing and responding to serious medical problems."[42]

Corizon has a record of minimizing costs by denying prisoners treatment. For example, the recommended treatment for a patient with a symptomatic hernia is prompt surgical repair.[43] Yet, in 2017, Corizon paid a class of current and former Florida state prisoners $1.7 million to settle a lawsuit that challenged the company's policy of refusing hernia surgeries "for the purpose of reducing costs and increasing profits."[44] Similarly, Alabama prisons—which have engaged

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[40] Beth Kutscher, *Rumble over jailhouse healthcare*, Modern Heathcare (Aug. 13, 2013), *available at* http://www.modernhealthcare.com/article/20130831/MAGAZINE/308319891.

[41] *Id.*

[42] Confidential Rebuttal Report of Robert L. Cohen, M.D., ¶ 7, *Parsons* v. *Ryan*, Case No. 2:12-cv-00601-NVW (Jan. 31, 2014), *available at* https://www.aclu.org/legal-document/parsons-v-ryan-confidential-rebuttal-report-robert-l-cohen-md.

[43] Compl. ¶¶ 23–26, *Copeland* v. *Jones*, Case No. 15-cv-00452-RH-CAS, Dkt. No. 1, (N.D. Fla. Sep. 16, 2015).

[44] *See id.* ¶ 1; Mary Ellen Klas, *State, former healthcare provider agree to settle suit over prisoners' untreated hernias*, Miami Herald (Apr. 9. 2017),

Corizon as their health care provider since 2007—spend among the least on health care per inmate in the nation.[45] Notably, among the policies being challenged in a class action suit pending against the Alabama Department of Corrections ("ADOC"), is a practice of denying medical care due to costs, including antiviral treatment for HCV.[46]

Abuses have also been reported in Kansas and Missouri. According to a recent report, although Corizon's contracts with the departments of corrections for Kansas and Missouri are worth nearly a combined $2 billion over 10 years, few state officials have any sense of how that money is being used to provide adequate care.[47] Indeed, Kansas's Republican chairman of the House Committee on

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http://www.miamiherald.com/news/politics-government/state-politics/article143376554.html.

[45] Southern Poverty Law Center, *Active Case: Braggs et al.* v. *Jefferson Dunn et al.* https://www.splcenter.org/seeking-justice/case-docket/braggs-et-al-v-jefferson-dunn-et-al (last visited Feb. 6, 2018).

[46] *See* Expert Report of Dr. Michael Puisis, *Braggs et al.* v. *Jefferson Dunn et al.*, Expert Report of Dr. Michael Puisis, Case No. 2:14-cv-00601-MHT-TFM, at 60; 140–43 (Jul. 5, 2016) *available at* https://www.splcenter.org/sites/default/files/documents/doc._555-3_-_expert_report_of_dr._michael_puisis.pdf (discussing cost as a barrier to treatment and discussing the provider-imposed difficulties of accessing treatment for Hepatitis C).

[47] *See* Andy Marso, *What is $2 billion buying Kansas and Missouri in prison health care? Few people know*, The Kansas City Star (Jan. 21, 2018), *available at* http://www.kansascity.com/news/politics-government/article195673934.html.

Corrections and Juvenile Justice has never "experienced a specific report in terms of Corizon or their performance in their contracts."[48]

While research suggests effective management and oversight are critical to the success of outsourcing prison health care services,[49] Missouri has failed to implement this. Instead, Corizon effectively self-monitors, directly paying the individual in charge of oversight and, upon her departure, having a hand in looking for her replacement.[50] An expert physician who testifies in correctional medical malpractices cases has described Corizon's policy of minimized treatment in Missouri and elsewhere as follows: "They're private, their goal is to make money, so they put policies in place that aren't necessarily (intended) to benefit the patient."[51]

Defendants' brief contends that Plaintiffs have overlooked the burdens associated with individualized treatment and the corresponding efforts such treatment would entail. (Appellants' Br. at 19–26.) In other words, their primary justification is a veiled appeal to cost: individualized treatment risks variation,

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[48] *Id.*

[49] *See* Pew Charitable Trusts, *State Prison Health Care Spending* at 13 (July 2014), http://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf.

[50] Andy Marso, *What is $2 billion buying Kansas and Missouri in prison health care? Few people know*, The Kansas City Star (Jan. 21, 2018), *available at* http://www.kansascity.com/news/politics-government/article195673934.html.

[51] *Id.*

variation often requires expenditure of excess resources, and that expenditure would be costly. This all but proves Plaintiffs' point. Defendants' policies are rooted in a single-minded emphasis on cost, which is best addressed on a classwide basis.

III. COURTS IN SIMILAR CASES HAVE CERTIFIED PLAINTIFF CLASSES

In other similar cases around the country, courts have certified classes of prisoner plaintiffs challenging policies and practices as improperly denying serious medical treatment for cost reasons. For example, in *Scott* v. *Clarke*, the court certified a class of female inmates who were denied treatment for "serious medical needs," including hepatitis C, because "[t]he essential questions in this case—questions of fact and questions of law—do not vary among class members" and include "whether the [state DOC's] contract system permits improper cost considerations to interfere with treatment of serious medical conditions."[52] And in *Parsons* v. *Ryan*, the Ninth Circuit affirmed a district court order granting class certification for Arizona state prisoners suing the Arizona Department of Corrections ("ADC") for "systemic deficiencies in ADC's statewide health care system."[53] Among the evidence considered by the district court was expert testimony that a "system-wide practice of not following the [ADC's formal]

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[52] 61 F. Supp. 3d 569, 585 (W.D. Va. 2014).

[53] 754 F.3d 657, 663 (9th Cir. 2014).

policies" pervaded because, among other things, defendants "failed to provide adequate staffing, supervision and resources to promote compliance."[54] Later in the case an expert report described how Corizon, one of ADC's health care providers, denied a prisoner standard medication for a serious chronic condition "due to cost."[55]

This case concerns a new class of treatment that is revolutionary, but admittedly expensive. With near-perfect efficacy rates and shortening treatment cycles, the only conceivable reason Defendants' treatment rates with the new drugs are so low is due to cost. The statistics support this inference: as of January 2015, only 5 out of 4,736 prisoners known to be infected with HCV were being treated,[56] while out of 100 people with hepatitis C, 60 to 70 will develop chronic liver disease, 5 to 20 will develop cirrhosis, and 1 to 5 will die from the consequences of

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[54] *Id*. at 669.

[55] Confidential Supplemental Report of Dr. Todd Randall Wilcox, M.D., at 17, *Parsons* v. *Ryan*, Case No. 2:12-cv-00601-NVW (Apr. 2, 2014), *available at* https://www.aclu.org/sites/default/files/field_document/Parsons%20v%20Ryan%20WilcoxExpertReport2014.04.02Supplemental.pdf (describing how the condition of prisoner with Crohn's disease deteriorated after Corizon denied him Remicade due to cost).

[56] Second Am. Compl. ¶ 51, Dkt. No. 30.

chronic infection (liver cancer or cirrhosis).[57] This extreme undertreatment cannot be credibly explained as being a product of individualized medical decisions.

Perhaps recognizing this implicitly, courts have repeatedly granted class certification where HCV-positive prisoners have recently challenged policies and procedures of denied HCV treatment following the rise of DAA drugs.[58] In July 2016, the District of Massachusetts granted certification to all people "who are or will be prisoners in the custody of the Massachusetts Department of Correction . . . and who have or will have Hepatitis C while in custody and have not yet been cured" in a case against a subsidiary of Centurion, LLC.[59] In May 2017, the Middle District of Tennessee granted class-action certification to HCV-positive prisoners filing suit against the TDOC, another jurisdiction that outsources its medical care to Centurion.[60] The court wrote: "Plaintiffs are not simply disagreeing with a doctor's course of treatment for a particular person. They are

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[57] CDC, *Hepatitis C FAQs for Health Professionals*, https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm (last visited Feb. 6, 2018).

[58] *See* Order Granting Motion for Class Certification, *Fowler* v. *Turco*, Case No. 1:15-cv-12298-NMG, Dkt. No. 46 (D. Mass. Jul. 22, 2016); Memorandum Granting Motion for Class Certification, *Graham* v. *Parker*, Case No. 3-16-cv-01954, Dkt. No. 32 (M.D. Tenn. May 4, 2017); Order Granting Motion for Class Certification, *Hoffer* v. *Jones*, Case No. 4:17-cv-00214-MW-CAS, Dkt. No. 152 (N.D. Fla. Nov. 17, 2017).

[59] Order Granting Motion for Class Certification, *Fowler* v. *Turco*, Case No. 1:15-cv-12298-NMG, Dkt. No. 46 (D. Mass. Jul. 22, 2016).

[60] Memorandum Granting Motion for Class Certification, *Graham* v. *Parker*, Case No. 3-16-cv-01954, Dkt. No. 32 (M.D. Tenn. May 4, 2017).

attacking TDOC's statewide policies and procedures applicable to all inmates with Hepatitis C."[61] And in November 2017, the Northern District of Florida granted class certification, noting that "Plaintiffs' claims [were] focused 'on Defendant's policy of non-treatment for HCV'" and "Defendant [had] not shown why differences in symptoms and treatment considerations should preclude awarding such class-wide relief."[62] There, not only was the class certified, but the court also ordered prison officials to provide treatment to HCV-positive prisoners using the latest generation of anti-viral drugs, pending resolution of the lawsuit.[63]

Here, the same result should hold. In January 2015, Defendant MDOC reported that it was treating 0.11% of HCV-positive inmates under its supervision or 5 inmates out of 4,736 inmates with known HCV infections.[64] These results are not plausibly the result of medical judgment but are explainable only by a central policy focused on cost.

IV. EXPANDED TREATMENT YIELDS ENORMOUS SOCIAL BENEFITS

The New England Journal of Medicine has labeled HCV-care in prisons a way "to efficiently identify and cure the greatest number of HCV-infected

[61] *Id.* at 7.

[62] Order Granting Motion for Class Certification at 5, 7, *Hoffer* v. *Jones*, Case No. 4:17-cv-00214-MW-CAS, Dkt. No. 152 (N.D. Fla. Nov. 17, 2017).

[63] Order Granting Motion for Preliminary Injunction at 1–2, 32, *Hoffer v. Jones*, Case No. 4:17-cv-00214-MW-CAS, Dkt. No. 153 (Nov. 17, 2017).

[64] Second Am. Compl. ¶ 51, Dkt. No. 30.

people."[65] Specifically, studies have found that treatment of chronic hepatitis C in U.S. prisons results in both improved quality of life and savings in cost for both the inmate and outside population.[66]

Screening in prisons, for example, could prevent between 4,200 to 11,700 liver-related deaths, 300 to 900 liver transplants, 3,000 to 8,600 cases of hepatocellular carcinoma and 2,600 to 7,300 cases of decompensated cirrhosis in the next 30 years.[67] Notably, among liver-related deaths averted by treatment, "80% would have occurred in the outside community."[68] These numbers have prompted economists to recognize that "[u]niversal opt-out HCV screening in prisons is highly cost-effective and would reduce HCV transmission and HCV-associated diseases primarily in the outside community" and "[i]nvesting in US prisons to manage hepatitis C is a strategic approach to address the current epidemic."[69] From a public health perspective, "the high concentration of patients

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[65] Josiah D. Rich et al., *Responding to Hepatitis C through the Criminal Justice System*, 370 N. Engl. J. Med. 20, 1872–74 (May 15, 2014), *available at* http://www.natap.org/2014/HCV/nejmp1311941.pdf.

[66] Tianhua He, et al., *Prevention of Hepatitis C by Screening and Treatment in United States Prisons*, Ann. Intern Med., 84–92 (Jan. 19, 2016), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4854298/.

[67] *Id*.

[68] *Id*.

[69] *Id*.

with [HCV] living in correctional institutions presents a critical opportunity to have a substantial effect on this epidemic."[70]

Admittedly, the cost of DAA drugs is high and, when combined with the prevalence of HCV, makes universal treatment costly. But similar impediments to treatment originally limited universal access to HIV medication.[71] As treatments for HIV evolved, however, insurers, government, and pharmaceutical companies worked together to bring medication prices to the point where all persons in need of treatment were able to afford and readily access it.[72] HCV therapies are on this path.

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[70] *Id.*

[71] Josiah D. Rich et al., *Responding to Hepatitis C through the Criminal Justice System*, 370 N. Engl. J. Med. 20, 1872–74 (May 15, 2014), *available at* http://www.natap.org/2014/HCV/nejmp1311941.pdf (arguing that HCV treatment plans should learn from correctional responses to the HIV epidemic since "[c]orrectional facilities faced similar cost and treatment challenges in responding to the HIV epidemic, which was even more complicated [than the HCV epidemic] because it required long-term treatment with ongoing monitoring").

[72] *See, e.g.*, Ryan White Comprehensive AIDS Resources Emergency Act (Ryan White CARE Act), Pub. L 101-381, 104 Stat. 576 (1990) (creating funding for HIV treatment in cases where uninsured or underinsured AIDS victims have no other resources available to obtain adequate treatment); *see also* Sarah Larney, et al., *"Seek, test, treat, and retain" for hepatitis C in the United States criminal justice system*, J. Prison Health, 164–171 (2014), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4358744 (describing development of "seek, test, treat and retain" (STTR) strategy to diagnose and treat "HIV epidemic" in criminal justice populations, and recommending applying STTR to HCV in the criminal justice system because "the resulting gains to public health would be substantial").

In addition, a new release of less expensive DAA drugs will enable insurers and pharmaceutical companies to expand access to HCV treatment. The new drug "Mavyret" has a "price tag of $26,400 for a course of treatment," which is "significantly below" that of comparable hepatitis C drugs.[73] As occurred in the aftermath of the HIV epidemic, federal programs and hospitals are working together to expand access to DAA drugs. A current federal program, for instance, allows eligible institutions, like hospitals, to receive steep discounts on hepatitis C and HIV medications.[74] In light of these new developments—and amid a pending class action alleging non-treatment for hepatitis C—the Tennessee Department of Corrections is taking steps to deliver treatment.[75] Rejecting a bid by Corizon, Tennessee awarded a contract to a medical provider that "approached Vanderbilt University Medical Center about a partnership that would allow the department to receive the favorable rates [for DAA drugs]."[76]

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[73] Michelle Andrews, *FDA's approval of a cheaper drug for hepatitis C will likely expand treatment*, NPR (Oct. 4, 2017), https://www.npr.org/sections/health-shots/2017/10/04/555156577/fdas-approval-of-a-cheaper-drug-for-hepatitis-c-will-likely-expand-treatment.

[74] *See* Dave Boucher, *New Tennessee prison health contract could top $473 million, points to Hepatitis C plan*, Tennesean (Aug. 7, 2017), https://www.tennessean.com/story/news/2017/08/07/massive-new-tennessee-prison-health-contract-points-possible-hepatitis-c-partnership/546417001/.

[75] *Id.*

[76] *Id*.

Rather than alleviate the spread of the hepatitis C epidemic, Defendants' systemic failure to treat HCV-positive inmates ensures that, upon release, these individuals are sicker, less employable, and more reliant on government programs for treatment.[77] Notably, Defendants' approach also has a disproportionately harmful effect on minority populations. "Racial and ethnic minority persons appear to comprise the majority of HCV burden in U.S. correctional settings,"[78] and African Americans are incarcerated in state prisons at more than five times the rate of whites.[79]

Cases with such sweeping civil rights implications and public health consequences, like that presently before the Court, are precisely the kinds of matters suited for classwide resolution. As the Supreme Court has emphasized, a "'[c]ivil rights case[ ] against parties charged with unlawful, class-based

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[77] *See* Tianhua He, et al., Prevention of Hepatitis C by Screening and Treatment in United States Prisons, Ann. Intern Med., 84–92 (Jan. 19, 2016), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4854298/.

[78] Sarah Larney, et al., *A systematic review and meta-analysis of racial and ethnic disparities in hepatitis C antibody prevalence in United States correctional populations*, Ann. Epidemiol, 570–78 (2016).

[79] Ashley Nellis, *The Color of Justice: Racial and Ethnic Disparity in State Prisons*, The Sentencing Project (Jun. 14, 2016), at 14, *available at* https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/.

discrimination'" is a "'prime example[ ]' of what (b)(2) is meant to capture."[80] To hold otherwise and effectively sanction delayed treatment and prolonged disease would risk significant constitutional harm inside prison walls and a poorer, sicker public outside of them, particularly among the most vulnerable members of our society.

[80] *Wal-Mart Stores, Inc.* v. *Dukes*, 564 U.S. 338, 361 (2011) (quoting *Amchem Prod., Inc.* v. *Windsor*, 521 U.S. 591, 614 (1997).

CONCLUSION

For the foregoing reasons, the District Court's class certification order should be affirmed.

Dated: February 6, 2018

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This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(a)(5) because it contains 5,110 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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I hereby certify that I electronically filed the foregoing *amicus curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system on February 6, 2018. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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