

2019

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Recommended Citation

Sara Rosenbaum, *Invented Purposes and Blue Sky Predictions: Why the Trump Administration Cannot Win the Medicaid Work Experiment Cases*, 29 Health Matrix 113 (2019)

Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol29/iss1/4>

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INVENTED PURPOSES AND BLUE
SKY PREDICTIONS:
WHY THE TRUMP ADMINISTRATION
CANNOT WIN THE MEDICAID WORK
EXPERIMENT CASES

Sara Rosenbaum[†]

In *Stewart v. Azar*,¹ a federal court vacated the Trump administration's decision to approve Kentucky HEALTH, a Medicaid work experiment that was to be carried out under § 1115(a) of the Social Security Act (§ 1115).² The *Stewart* decision applies only to Kentucky's plan. The Court expressly refused to rule on whether demonstrations that reduce Medicaid eligibility, such as work requirements, are inherently unlawful under § 1115;³ neither did the Court directly address the legality of the nationwide solicitation⁴ of

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1. *Stewart v. Azar*, 313 F.Supp.3d 237 (D.D.C. 2018).
2. 42 U.S.C. § 1315(a) (2014); Section 1315(a) allows for flexibility to implement Medicaid at the state level by allowing states to tailor their programs that help promote Medicaid as long as the Health and Human Services Secretary approves the proposed program. *But see Texas v. United States*, 340 F.Supp.3d 579 (N.D.Tex. 2018) (holding 42 U.S.C. § 1315 unconstitutional as non-severable).
3. *Stewart*, 313 F.Supp.3d, at 272. Some, including this author, have argued that 1115 does not permit waiver designs that restrict eligibility. *See, e.g.*, Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 NEW ENG. J. MED. 788, 789 (2018).
4. DEP'T HEALTH & HUM. SERVS., STATE MEDICAID DIRS. LETTER, RE: OPPORTUNITIES TO PROMOTE WORK AND COMMUNITY ENGAGEMENT AMONG MEDICAID BENEFICIARIES (Jan. 11, 2018),

Medicaid work experiments on which the administration based its review and approval process. But a careful parsing of the decision underscores the magnitude of the uphill climb the administration faces in attempting to move forward with § 1115 Medicaid work experiments. The fact that the Arkansas work experiment⁵ has been implemented – to predictably disastrous effect with mass disenrollment ongoing as of December 2018, that in turn caused the state and the federal

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>. The solicitation appeared two months after a speech by CMS Administrator Seema Verma at the National Association of State Medicaid Directors. *Speech: Remarks by Administrator Seema Verma at the National Association of Medical Directors (NAMD) 2017 Fall Conference*, CTRS. MEDICARE & MEDICAID SERVS. (Nov. 7, 2017), <https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicaid-directors-namd-2017-fall>. The Administrator used her speech to promote work requirements in the context of reducing Medicaid’s size and returning it to what she viewed as its proper mission of insuring “the most vulnerable.” This reinforced the Trump Administration’s position, first expressed in a March 2017 letter to the nation’s Governors that “[t]he expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working age adults without dependent children was a clear departure from the core, historical mission of the program.” It became clear that § 1115 work experiments were about reducing the size of the program and eliminating people viewed as outside its “historical mission.” HEALTH AND HUM. SERVICES, LETTER FROM THE SECRETARY (2017), <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>.

5. Some recipients of Medicaid in Arkansas must work at least 80 hours a month. Benjamin Hardy, *Update: Work Requirement Ends Medicaid Coverage for 4,600 more Arkansans in December*, ARK. TIMES (Dec. 17, 2018, 1:08 PM), <https://www.arktimes.com/ArkansasBlog/archives/2018/12/17/work-rule-ends-medicaid-coverage-for-4600-more-arkansans-in-december>. Letter from Seema Verma, Administrator of the Centers for Medicare and Medicaid Services, to Cindy Gillespie, Director of Arkansas Department of Human Services (Mar. 5, 2018) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf> (approving the Arkansas work amendment to its previous 1115 Medicaid “private option” demonstration). See J. Craig Wilson & Joseph Thompson, *Nation’s First Medicaid Work Requirement Sheds Thousands from Rolls in Arkansas*, HEALTH AFF. (Oct. 2, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181001.233969/full/>. The magnitude of the harm caused by the Arkansas experiment has been considerable enough to prompt the Medicaid and CHIP Payment and Access Commission (MACPAC), an advisory body to Congress, to call for a “pause in disenrollment” until federal and state officials could ascertain the reasons underlying widespread (in excess of ninety percent) failure to comply with reporting rules. See PENNY THOMPSON, MEDICAID & CHIP PAYMENT & ACCESS COMM’N, LETTER TO SECRETARY ALEX AZAR (Nov. 8, 2018), <https://www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf> (regarding Arkansas Medicaid work requirement).

government to already begin modifying its crucial reporting requirements – simply has happened because the lawsuit to stop it was not filed until several months after its June 1, 2018 start date.⁶

To be sure, each effort to stop an approved Medicaid work experiment likely will be fought on its own terms, given the fact that it is the actualization, not the concept, that a court (presumably the same court in each case, since they all are expected to be filed in the District of Columbia Circuit) is reviewing. Indeed, at least in minor respects, the approved demonstrations can differ on matters such as the ages of the people subject to the requirement, the precise scope of the exemptions, the work and reporting rules, and other related factors.⁷

But in the end, *Stewart* points to the degree to which, as broad as § 1115's experimental authority might be, the reach simply is too far where an idea as fundamentally problematic in both concept and execution as a work requirement is concerned. To be sure, other § 1115 demonstrations, which historically have laid the foundation for some of Medicaid's most important advances in the areas of eligibility, coverage, and program administration,⁸ have tested eligibility restrictions. This is most clearly the case with Indiana,⁹ which received permission from the Obama Administration, as part of its Affordable Care Act (ACA) Medicaid expansion demonstration, to test premiums whose scope not

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6. *Gresham v. Azar*, No. 1:18-cv-01900 (D.D.C., filed Aug. 14, 2018).
 7. The Kaiser Family Foundation, as it does with all things Medicaid, offers an excellent tracker that provides pretty much real-time, detailed information on each § 1115 Medicaid work demonstration as well as other § 1115 projects. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, HENRY J. KAISER FAM. FOUND., <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/> (last updated Jan. 23, 2019). As of this date, seven state Medicaid work requirement demonstrations had been approved, with another eight pending.
 8. Sara Rosenbaum & Carla Hurt, *How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations*, COMMONWEALTH FUND (Dec. 2014), https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2014_dec_1794_rosenbaum_s_tates_expanding_medicaid_section_1115_rb_v3.pdf.
 9. Approval of Indiana can be found at CENTERS FOR MEDICARE AND MEDICAID SERVICES EXPENDITURE AUTHORITIES, NO. 11-W- 00296/5, HEALTHY INDIANA PLAN, (Feb. 1, 2018), https://www.in.gov/fssa/hip/files/IN-HIP-1115-Approval-Package_2-1-2018.pdf. An explanation of the Indiana demonstration can be found in MaryBeth Musumeci et al., *Approved Changes in Indiana's Section 1115 Medicaid Waiver Extension*, HENRY J. KAISER FAM. FOUND. (Feb. 9, 2018), <https://www.kff.org/medicaid/issue-brief/approved-changes-in-indianas-section-1115-medicaid-waiver-extension/>.

only exceeds the rules normally allowed under federal Medicaid law¹⁰ but that also are tied, for certain beneficiaries, to disqualification (i.e., lockout) periods for nonpayment. Yet as harsh as the Indiana policy is, the terms of the demonstration permit certain mitigation steps (such as premium payments by third parties), more importantly, the Indiana demonstration, in the end, represents a tough but logical extension of existing Medicaid policies governing premiums.

Work requirements, on the other hand, represent a whole new ballgame in Medicaid. They amount to an eligibility restriction never enacted by Congress as an independent Medicaid condition of coverage.¹¹ The experiments rest on logic that simply does not withstand even limited scrutiny, require a suspension of disbelief regarding Medicaid's purposes, and are premised on assertions regarding their potential to produce a beneficial impact that are simply untethered from all known evidence. Although arguably § 1115 offers precisely the vehicle for testing new coverage policies, bootstrapping a work experiment into § 1115 is simply an impossibility.¹²

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10. An explanation of how the Indiana premiums differ from what is normally permitted under federal law, thereby necessitating a waiver of federal law under §1115(a), can be found in Alexandra Gates et al., *Healthy Indiana Plan and the Affordable Care Act*, HENRY J. KAISER FAM. FOUND. (Dec. 18, 2013), <https://www.kff.org/medicaid/fact-sheet/healthy-indiana-plan-and-the-affordable-care-act>. Essentially Indiana is permitted to impose premiums on beneficiaries who otherwise would be exempt under Medicaid's premium provisions (i.e., people with incomes under 150 percent of the federal poverty level) and to disqualify for a fixed period of time (i.e., lock out) people with incomes above 100 percent of poverty who fail to pay their premiums.
 11. Legislation that passed the House of Representatives in 2017 and was pending in the Senate would have given states the option to include work as a condition of eligibility. See American Health Care Act, H.R. 1628, 115th Cong. §§ 117, 130 (2017); Better Care Reconciliation Act, H.R. 1628, 115th Cong. (2017). The 1996 welfare reform legislation authorizes states to deny Medicaid to recipients of Temporary Aid to Needy Families (TANF) who fail to comply with TANF work requirements. For a discussion regarding states considering extending disqualification from Medicaid or Supplemental Nutrition Assistance (SNAP) benefits in the case of TANF recipients who experience lost or reduced benefits. See LaDonna Pavetti, *TANF Studies Show Work Requirement Proposals for Other Programs Would Harm Millions, Do Little to Increase Work*, CTR ON BUDGET & POL'Y PRIORITIES (Nov. 13, 2018), <https://www.cbpp.org/research/family-income-support/tanf-studies-show-work-requirement-proposals-for-other-programs-would>.
 12. In another era, a demonstration carrying as much risk of harm to the poor as mandatory Medicaid work experiments are proving to do would not have gone forward but would have been stopped as experiments on human subjects that grossly exceeded the minimal level of risk allowed in social welfare experimentation. In 1983, however, the Reagan Administration eliminated § 1115 demonstrations from the protective umbrella of the Common Rule governing federally assisted research on human subjects.

The *Stewart* decision rested on a crucial consideration, namely, whether a work requirement could be said to be “likely to assist in promoting the objectives”¹³ of the Medicaid program. As a result, the decision came down to two questions. First, what is the purpose of Medicaid? Second (assuming that Medicaid’s purposes are broad enough to encompass ones that would disqualify people from coverage if they do not satisfy work and reporting rules), under what set of facts could such an experiment proceed, and what evidence would need to be presented to a court to make the decision a reasonable one? Thus, if the Trump administration is to prevail, it will need to convince a court of two things: first, that Medicaid’s purposes extend beyond the provision of medical assistance, since virtually all proposed work demonstrations show a reduction, rather than an expansion, of eligibility;¹⁴ and second, that evidence supports a decision to proceed because the benefits to be gained in advancing Medicaid’s additional – and arguably competing – purposes outweigh the loss of coverage.

That the circumstances that gave rise to the *Stewart* case will recur is not open to debate. Multiple states are seeking to replicate work experiments. The Arkansas demonstration, which removed yet another 4600-plus people from Medicaid in November 2018,¹⁵ is in litigation now. In November 2018, in the wake of the decision vacating his initial approval, the Secretary of Health and Human Services (Secretary) re-approved the Kentucky work experiment with virtually no changes,¹⁶

No administration since has restored the protections. A question for another day is whether, apart from the Common Rule, a demonstration that fails to carry safeguards against risks to human subjects could be considered arbitrary and capricious under the Administrative Procedure Act. See Sara Rosenbaum, *Weakening Medicaid From Within*, AM. PROSPECT (Oct. 19, 2017), <https://prospect.org/article/weakening-medicaid-within>.

13. *Stewart v. Azar*, 313 F. Supp. 3d 237, 254 (D.D.C. 2018).
14. See, e.g., Sara Rosenbaum et al., *State 1115 Proposals to Reduce Medicaid Eligibility: Assessing Their Scope and Projected Impact*, COMMONWEALTH FUND (Jan. 11, 2018), <https://www.commonwealthfund.org/blog/2018/state-1115-proposals-reduce-medicaid-eligibility-assessing-their-scope-and-projected> (reviewing work experiment proposals submitted to date).
15. ARK. DEP’T HUMAN SERVS., ARKANSAS WORKS PROGRAM (2018), http://d31hzhk6di2h5.cloudfront.net/20181217/79/92/18/6e/eeaf1dc6701dc28a1244276a/181217_AWreport.pdf.
16. See PAUL MANGO, CTR. MEDICARE & MEDICAID SERV., LETTER TO CAROL H. STECKEL (Nov. 20, 2018), <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf>. The second approval letter is in part a rubber stamp of the first approval, in part a defense of the agency’s insistence on creating new purposes for Medicaid that in turn would enable approval of a demonstration whose impact is to remove people from the program, and

and the latest decision is now subject to a new challenge.¹⁷ In renewing his approval, the Secretary employed the same arguments regarding purpose, once again ignored the impact of the experiment on coverage for tens of thousands of people, and made the same baseless, evidence-free assertions regarding the positive impact of the plan on which he had relied in the first approval and that were discredited by the Court in its decision. With a total of five work experiments approved, and at least ten in the pipeline,¹⁸ this is a good time to explore *Stewart* in more depth.

As in other cases that have challenged the legality of § 1115 experiments, the starting point for the Court was to ascertain the purpose of Medicaid, since § 1115 is confined to experiments that the Secretary finds are “likely to assist in promoting” the objectives of the Social Security Act program that is the subject of the demonstration.¹⁹ Under the Administrative Procedure Act’s “arbitrary and capricious” standard governing judicial review,²⁰ the court concluded that its duty was to review the legality of the work experiment (known as Kentucky HEALTH)²¹ “as a whole,”²² rather than approaching each experimental element piecemeal. This meant a review of a bundled package that included: work and reporting requirements; elimination of retroactive Medicaid eligibility for certain populations; coverage and benefit restrictions; higher patient cost-sharing; and imposition of lock-out periods for failure to comply with work and related reporting requirements as other new requirements related to the annual redetermination process and notifying the state regarding changes that could affect eligibility. Each element required separate waivers under § 1115(a) of underlying federal law; together they made up a single, integrated experimental approach to Medicaid, now under review. The

in part an explanation of why public commenters erred in believing the state’s own estimates in its 2017 proposal that over 95,000 people would lose coverage by the demonstration’s fifth year.

17. *Id.*
18. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, *supra* note 7.
19. *Stewart v. Azar*, 313 F.Supp. 3d. 237, 260 (D.D.C. 2018).
20. 5 U.S.C. § 706(2)(a) (2012).
21. Kentucky HEALTH actually is part of a larger demonstration known (confusingly) as KY HEALTH. See discussion of scope of review, *Stewart*, 313 F. Supp. 3d at 257. KY HEALTH in its entirety also included experimental expansion of access to residential substance abuse treatment services beyond that normally allowed under federal law. Plaintiffs did not challenge this component of the state’s demonstration, and the court concluded that this portion of the approval was legally separate and distinct from Kentucky HEALTH..
22. *Stewart*, 313 F.Supp. 3d. at 257.

purpose of this bundled approach to Medicaid, according to the Secretary, was to promote Medicaid’s purposes, which he defined as “improv[ing] health outcomes, promot[ing] increased upward mobility and improved quality of life, increas[ing] individual engagement in health care decisions, and prepar[ing] individuals who transition to commercial health insurance coverage to be successful in this transition.”²³

The question, according to the Court, was whether this bundle in fact was approvable; that is, “whether the Secretary acted arbitrarily or capriciously in concluding that Kentucky HEALTH was ‘likely to assist in promoting the objectives’ of the Medicaid Act.”²⁴ The Court stressed that its role was simply to determine whether the Secretary had engaged in “reasoned decisionmaking” involving consideration of all relevant and “salient factor[s]” and evidence in order to assess whether the decision rested on more than “conclusory statements” or “entirely [failed] to consider an important aspect of the problem” and “the consequences of his actions.”²⁵ Under the Chevron doctrine, this meant deferring to the governing agency in the event of statutory ambiguity.²⁶

But in this case, the Court concluded, there was no need to give deference since the statute is clear as to its purposes. In determining purpose, moreover, the Court looked not simply to the traditional source that courts consult – Medicaid’s appropriation provision²⁷ – but to the fuller Medicaid text.²⁸

The appropriations provision specifies that the purpose of Medicaid is, in pertinent part, to enable

each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance . . . [to] 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.²⁹

23. *Id.* at 262.

24. *Id.* at 259.

25. *Id.* (internal quotations omitted).

26. *Chevron U.S.A., Inc. v. Nat. Res. Def. Council*, 467 U.S. 837, 842-43 (1984) (establishing the basic doctrine that guides judicial review of administrative decisions).

27. 42 U.S.C. § 1396(a)(1) (2018).

28. *Stewart*, 313 F.Supp. 3d. at 260.

29. *Id.*

But this section of the law dates to 1965 – nearly a half century prior to the ACA Medicaid expansion – and focuses only on those populations whose eligibility was established under the original law. For this reason, the Court also looked to subsequent amendments to that section of the law defining who is entitled to medical assistance, including the eligibility expansions to the statute codified as part of the ACA.³⁰

Through this further examination of Medicaid’s statutory text adding new eligibility groups to those entitled to receive medical assistance, the Court concluded that the purpose of the law, as expressed in its appropriation provision, in fact clearly extended to all eligibility groups subsequently added to the statute – from the pregnant women added in 1984 as a new and distinct eligibility group through the low income working-age adults not otherwise eligible for Medicaid under traditional program rules, as added by the ACA. All subsequently added groups, according to the Court, clearly enjoy the same statutory purpose as those eligibility categories contained in the initial law. Indeed, no other conclusion was possible in the Court’s view given the United States Supreme Court’s decision in *National Federation of Independent Businesses v Sebelius*,³¹ which interpreted the ACA’s Medicaid statutory amendments as having transformed Medicaid from its original limited role into “an element of a comprehensive national plan to provide universal health insurance coverage.”³² Because Kentucky had expanded its plan in 2014 to include ACA adults, those adults became part of the State’s coverage plan, entitled to protections no less stringent in an experimental context than those accorded other beneficiaries.³³ This meant, in turn, that their fate under the demonstration became a “salient factor” in the federal review process.

For this reason, it became fatal to the approval that the Secretary simply ignored the impact of putting health insurance at risk for tens, if not hundreds, of thousands of people. By the Secretary’s own admission, agency review was confined to confirming the assertions of its own officials³⁴ that the demonstration would improve health outcomes, address behavioral and social factors that influence health,

30. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018).

31. Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519, 583 (2012).

32. *Id.*

33. Louise Norris, *Kentucky and the ACA’s Medicaid Expansion*, HEALTH INS. (Nov. 25, 2018), <https://www.healthinsurance.org/kentucky-medicaid/>; *Stewart*, 313 F.Supp. 3d. at 261.

34. *Stewart* 313 F.Supp. 3d at 261. *See supra* note 4 regarding the speech by CMS Administrator Seema Verma.

incentivize beneficiaries to engage in their own health care, and familiarize beneficiaries with commercial insurance design.³⁵

While those may be worthy goals, there was a notable omission from the list: whether Kentucky HEALTH . . . would help provide health coverage for Medicaid beneficiaries. That is, would Kentucky HEALTH help or hurt states in “funding . . . medical services for the needy”? By his own description, the Secretary “entirely failed to consider” that question.³⁶

So completely did the Secretary ignore this central question that he never provided a bottom-line estimate of how many beneficiaries would lose coverage.³⁷ Furthermore, despite an administrative record replete with comments regarding likely coverage losses over the life of the experiment as a result of the new eligibility restrictions and “clerical and tracking errors” that surely would follow,³⁸ the Court found that “the record contains a rather stunning lack” of discussion about the effects of the demonstration on health coverage.³⁹

The only sign that the Secretary understood the coverage impact was the presence of the exemptions he approved under the state’s proposals. This, according to the Court, was “[no] answer at all,”⁴⁰ stating “[a]lthough Kentucky’s initial project may have thus included

35. *Stewart* 313 F.Supp. 3d at 261-262.

36. *Id.* (internal citations omitted).

37. The state estimated a loss of 95,000 beneficiaries by the fifth year of the experiment, while scholar amici estimated losses of between 175,000 and 297,000 – about two-thirds of Kentucky’s total expansion population. *Id.*

38. *Id.* at 262-63.

39. *Id.* at 263.

40. The January 2018 solicitation (DEP’T HEALTH & HUM. SERVS. *supra*, note 4), identified certain exemptions that states’ applications would be expected to contain, with no discussion of the risks facing non-exempt beneficiaries. The January 2018 solicitation did not discuss the potential effects of the demonstration on non-exempt populations, other than to predict, based on no evidence, that people would experience a rise in income, greater access to health insurance, and better health. In the second Kentucky approval letter, issued November 20th, the Secretary for the first time seemed to acknowledge the risks facing those losing insurance. CMS added the following specific condition to its “Waiver List” accompanying the approval letter, at Paragraph 47: “Provide each beneficiary whose eligibility has been suspended with information on how to access primary care and preventative [sic] services at low or no cost to the individual. This material will include information about free health clinics and community health centers including clinics that provide behavioral and substance use disorder services. Kentucky shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries whose eligibility has been suspended.” PAUL MANGO, *supra* note 16.

adequate protections for ‘vulnerable’ individuals, this was not enough for the Secretary to rubber-stamp it. . . . The Secretary . . . cannot limit his review to only ‘vulnerable individuals.’ . . . He must consider coverage to all groups enrolled in the project.”⁴¹

Thus, the existence of exemptions for some did “not establish that the Secretary [had] ‘adequately analyzed’ coverage loss” for the majority of beneficiaries subject to the experiment.⁴²

The Secretary then attempted to argue that in fact the 95,000 pegged to lose their coverage might not do so at all but “maybe . . . will instead transition to ‘employer-sponsored and commercial coverage.’”⁴³ To this the Court pointed out that, in fact, the Secretary had made “no such finding.”⁴⁴

While the agency spoke generally of “creating incentives for individuals to obtain and maintain coverage through private, employer-sponsored insurance,” it cited no research or evidence that this would happen, nor did it make concrete estimates of how many beneficiaries might make that transition. And, of course, it is not obvious that the community-engagement requirement alone would help a person shift to private insurance. As the Secretary stresses, this is not a work requirement; individuals can meet it, for example, by volunteering While those unpaid activities may have long-term benefits, he never discussed how they will promote a “transition from Medicaid to commercial coverage.”

The Court thus cannot credit the Secretary’s speculations now. “[T]he mere fact that there is some rational basis within the knowledge and experience” of the agency, “under which [it] might have justified its conclusion, “will not suffice to validate agency decisionmaking.” . . . Although it may “uphold a decision of less than ideal clarity if the agency’s path may reasonably be discerned,” it cannot infer an agency’s reasoning from mere silence or where the agency failed to address significant objections and alternative proposals.⁴⁵

In the end, it is no surprise that the Secretary simply sought to change the subject by inventing new purposes for Medicaid, followed by evidence-free, blue-sky predictions regarding the benefits of a work requirement. Even a cursory review of the literature on the effects of

41. *Stewart*, 313 F. Supp. 3d at 263-264.

42. *Id.*

43. *Id.* at 264.

44. *Id.*

45. *Id.* (internal citations omitted).

work on health shows that work has no causal impact on health; at most, the evidence shows that working simply reflects better health.⁴⁶ Furthermore, all available evidence, much from government-funded research, shows that work requirements in public assistance programs have, at best, limited short-term effects on income and fail to produce lasting effects.⁴⁷ A deluge of government data show that poor part-time workers generally have limited access to employer benefits, even when working.⁴⁸ One study focusing on Arkansas (like Kentucky, a high poverty southern state) found that in 2017, exactly 5.2% of small firms offered employee health benefits to their part-time workers.⁴⁹ Furthermore, the evidence is positively overwhelming regarding the impact of Medicaid on access to coverage and care.⁵⁰ It should come as no surprise that the Secretary wanted to avoid this evidence, both generally as well as the evidence submitted (twice) for the record.

46. Larisa Antonisse & Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review*, HENRY J. KAISER FAMILY FOUND. (Aug. 7, 2018), <https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/>; Brief for Deans, Chairs, and Scholars as *Amici Curiae* in Support of Plaintiff at 16, *Stewart v. Azar* 313 F.Supp. 3d. 237 (2018) (Civil Action No. 18-152 (JEB)).
47. Brief of Deans Chairs and Scholars, *supra* note 46; Pavetti, *supra* note 11.
48. Among poor adults ages eighteen through sixty-four, seventeen percent nationwide have access to employer benefits. In Kentucky this figure is eleven percent. See *Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100% FPL)*, HENRY J. KAISER FAM. FOUND. (2017), <https://www.kff.org/other/state-indicator/poor-adults/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. The evidence shows that half of poor working-age adults are working. Leighton Ku & Erin Brantley, *Medicaid Work Requirements: Who's At Risk?*, HEALTH AFF. BLOG (Apr. 12, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170412.059575/full/>. These two figures, taken together, suggest that employer benefits are a rarity for poor workers.
49. Emily M. Johnston et al., *Arkansans Losing Medicaid Due to Work Requirements are Likely to Face Limited Private Insurance Options*, URBAN WIRE (Oct. 29, 2018), <https://www.urban.org/urban-wire/arkansans-losing-medicaid-due-work-requirements-are-likely-face-limited-private-insurance-options>.
50. Sara Rosenbaum et al., *Will Evaluations of Medicaid 1115 Demonstrations That Restrict Eligibility Tell Policymakers What They Need to Know?*, COMMONWEALTH FUND, (Dec. 2018), <https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/evaluations-medicaid-1115-restrict-eligibility>; Larisa Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, HENRY J. KAISER FAMILY FOUND. (Mar. 28, 2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

Perhaps the biggest irony of all is that, despite reinventing Medicaid as a program whose purpose is to improve health through self-sufficiency, the Trump Administration's own January 2018 solicitation to state Medicaid Directors made it clear that demonstration states would not be able to use federal Medicaid funds for education, job training, or employment supports. In other words, states would be entirely on their own for (the not inconsiderable) costs associated with community engagement, including job training, job placement, employment supports, other community engagement programs, and job development in underserved, highly impoverished communities where jobs are scarce. Despite evidence that work programs aimed at the poor are effective only where well-funded and well-developed,⁵¹ the administration declared states ineligible, under the terms of the solicitation, to use federal Medicaid financing to offset these job creation efforts and barred states from applying federal savings from enrollment reductions toward such programs.⁵² No wonder. The purpose of Medicaid is to provide medical assistance, not to support work programs.

Faced with these facts, the Court did the inevitable and vacated Secretarial approval:

At bottom, the record shows that 95,000 people would lose Medicaid coverage, and yet the Secretary paid no attention to that deprivation. Nor did he address how Kentucky HEALTH would otherwise help “furnish . . . medical assistance.” In other words, he glossed over “the impact of the state’s project” on the individuals whom Medicaid “was enacted to protect.” By doing so, he “failed to consider adequately” a salient purpose of Medicaid and, thus, an important aspect of the problem.⁵³

As noted, the Secretary has now approved Kentucky HEALTH a second time. This time, to his arsenal of new purposes and blue-sky claims, he has attempted to reframe Kentucky HEALTH not as a sanctioned experiment in reducing coverage but as an experimental expansion, on the ground that the state is free to eliminate the expansion group at any time. As noted, although there is precedent for § 1115 eligibility expansions that allow expansion under more limited conditions, using § 1115 to cull the rolls has never been permitted. It is one thing to, as Indiana was permitted to do in the case of enforceable premiums, extend what are already statutorily optional eligibility

51. Leighton Ku et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?*, COMMONWEALTH FUND (Nov. 6, 2018), <https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/medicaid-work-requirements-will-they-help-jobs-health>.

52. DEP'T HEALTH & HUM. SERVS., *supra* note 4, at 8.

53. *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2018).

conditions to additional groups on an experimental basis. It is quite another to use § 1115 to reduce enrollment through eligibility restrictions that have never been independently sanctioned by Congress. Indeed, given the reasoning in *Stewart*, it is hard to believe that experiments aimed at removing enrolled beneficiaries from the program would ever be consistent with § 1115. As the court reasons, a clear reading of the statutory text extends Medicaid's purpose – to provide medical assistance to eligible people – to all program beneficiaries. Thus, in order to exercise his authority, the Secretary must show that he considered the impact of the demonstration on all affected populations, not only those whom he professes to treat as the “most vulnerable.” Medicaid § 1115 demonstrations are not some sort of exercise in population beneficence, they are intended to help policymakers gain a better understanding of how best to promote the program's purposes. This positive purpose underlays the origins of § 1115,⁵⁴ and it remains true today.⁵⁵

There may come a time when Congress decides to give states program options to introduce general restrictions or to cover less than the full expansion group. But for now, § 1115 is not a mechanism for rationing health care or causing collateral damage for some warped perception of the greater good. It is a means of making Medicaid work better for all who are entitled to it.⁵⁶

54. Brief of Deans Chairs and Scholars, *supra* note 46, at 9.

55. *See About Section 1115 Demonstrations*, CTR. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html> (last visited Feb. 1, 2019).

56. On March 27, 2019 the District of Columbia District Court found changes unresponsive to the instructions on remand and the Kentucky *vacatur* was reaffirmed and extended to Arkansas. Sara Rosenbaum & Alexander Somodevilla, *Inside the Latest Medicaid Work Experiment Decisions: Steward v Azar and Gresham v Azar*, HEALTH AFF. BLOG (Apr. 2, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190402.282257/full/>.