Nos. 20-37, 20-38

IN THE

Supreme Court of the United States

ALEX M. AZAR, II, SECRETARY
OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,

v.

CHARLES GRESHAM, ET AL.,
Respondents.

ARKANSAS
Petitioner,

v.

CHARLES GRESHAM, ET AL.,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE D.C. CIRCUIT

BRIEF OF *AMICUS CURIAE* THE FOUNDATION FOR GOVERNMENT ACCOUNTABILITY IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST[1]

The Foundation for Government Accountability (FGA) is a nonpartisan, nonprofit organization that helps millions achieve the American dream by improving welfare, work, and healthcare policy at both the state and federal levels. Launched in 2011, FGA promotes policy reforms that seek to free individuals from the trap of government dependence, restore dignity and self-sufficiency, and empower individuals to take control of their futures.

Since its founding, FGA has helped achieve more than 200 policy reforms in 34 states that removed government barriers to opportunity and helped 9.5 million individuals move off welfare. FGA supports its mission by conducting innovative research, deploying outreach and education initiatives, and equipping policymakers with the information they need to achieve meaningful reforms.

The decisions below erroneously halted Arkansas' successful pilot program that tied Medicaid benefits for able-bodied individuals without dependents to work or community engagement requirements. In doing so, the D.C. Circuit endorsed an improperly narrow view of Medicaid's purpose as being solely to provide and expand health coverage. But Medicaid's

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[1] Pursuant to this Court's Rule 37.6, counsel for *amicus curiae* certifies that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than *amicus curiae* or its counsel has made a monetary contribution to the preparation or submission of this brief. The parties have consented to the filing of this brief.

purposes are not so limited. Congress has indicated throughout the statutory scheme that the massive federal-state Medicaid program is broadly concerned with the health and independence of individuals rather than coverage alone. And extensive research, including research conducted by FGA, has shown that community engagement requirements improve individuals' overall health, well-being, and self-sufficiency and help transition them off public assistance programs. Accordingly, this case directly implicates FGA's core mission of helping individuals live healthy, independent, and fulfilling lives.

INTRODUCTION AND SUMMARY OF ARGUMENT

The D.C. Circuit erroneously concluded that Medicaid's sole objective is to expand coverage, and that states are powerless to adopt common-sense reforms that would improve beneficiaries' health and help them ultimately transition off public assistance programs. But Medicaid is at its core a *health*-care program, aimed at increasing coverage while simultaneously improving the health, independence, and general well-being of its recipients. The D.C. Circuit's impermissibly narrow focus on coverage alone—and its reliance on a single, decades-old statutory provision to determine the sole purpose of the entire program—undermine the Medicaid statutes' many other important goals.

The D.C. Circuit's approach to the statute also undermines the principles of cooperative federalism at the heart of the massive federal-state Medicaid program. Congress designed Medicaid's waiver

mechanism for pilot programs to allow states to experiment with different approaches based on the latest research and the unique circumstances in each state. Yet the decision below significantly curtails states' ability to innovate and experiment with policy reforms that can improve health outcomes, promote self-sufficiency, and ultimately reduce program expenditures.

State experimentation with programs like the one Arkansas adopted here is especially important given that extensive research—including research conducted by FGA—shows the benefits of work and community engagement requirements in connection with public assistance programs. Without meaningful work, individuals are almost always relegated to poverty. By linking work and community engagement to public assistance, states can help break the cycle of poverty and reduce beneficiaries' need for such programs in the first place. Numerous studies have shown that states that implement work requirements have succeeded in raising incomes, improving health outcomes, and promoting independence.

But the benefits of such programs do not stop there. By helping individuals achieve self-sufficiency and reducing the need for public assistance, community engagement requirements also steward scarce resources and ensure that program funding remains available to the most vulnerable. Medicaid spending across the country is rising every day and is often the single largest expenditure in state budgets. This unsustainable spending—especially on those who are capable of self-sufficiency, *i.e.*, able-bodied adults without dependents—is breaking state budgets

and crowding out funding for other important state programs such as education and transportation. And the unsustainable demand for Medicaid funding is relegating those who are most vulnerable and who require the most assistance to the sidelines. Today, more than 650,000 individuals across the country are on waitlists for important care even as program spending continues to skyrocket.

A number of states have already demonstrated that work and community engagement requirements can be an important part of the solution to these problems. Indeed, before the courts below halted Arkansas' pilot program, it was already producing impressive results. This is no surprise given that Arkansas' program was based on sound research showing that work and community engagement requirements help combat poverty, improve the health and well-being of participants, and preserve scarce program resources.

Finally, the COVID-19 pandemic and associated economic contraction only underscore why Arkansas' pilot project is sound policy. Arkansas' flexible program allows compliance through a variety of activities, including looking for work, engaging in job training, seeking education, or volunteering. Thus, even for individuals impacted by COVID-19 or job loss, there is significant flexibility to ensure that they are engaging in activities that will keep them involved in the community and build skills for the future. The pandemic and economic contraction make policies like Arkansas' more important, not less. The decision below should be reversed.

ARGUMENT

I. The D.C. Circuit erred by construing the objectives of the Medicaid program far too narrowly.

The court of appeals concluded that the *sole* objective of the Medicaid program is to give health coverage to more people "*without any restriction geared to heathy outcomes, financial independence or transition to commercial coverage*." Pet. App. 16a (emphasis added). That holding is wrong for several reasons. First, the D.C. Circuit's impermissibly narrow view of the statutory objectives turns Medicaid into a one-way ratchet. If providing more coverage is Medicaid's only goal, then no initiative or program that seeks to transition recipients off the program and help them become self-sufficient would ever be permissible. It is inconceivable that Congress would have taken such a counterintuitive approach to a program that is breaking government budgets at both the state and federal levels.

The D.C. Circuit's approach to the statute also undermines the principles of cooperative federalism at the heart of Medicaid. The clear purpose of Medicaid's waiver mechanism for pilot programs is to ensure that states are free to experiment with different approaches based on the latest research the unique conditions in each state. The decision below significantly curtails states' ability to innovate and experiment with programs that will improve health outcomes while reducing program expenditures.

Medicaid is a *health*-care program, not merely a cost-covering program. The D.C. Circuit correctly

recognized that expanding healthcare coverage is a "principal objective of Medicaid." Pet. App. 9a. But it is not the only one. Throughout the Medicaid statutes—which have been amended many times since the program was first enacted—there are numerous instances in which Congress sought to achieve goals beyond simply giving coverage to the maximum number of people. For example, the Medicaid statues are replete with provisions requiring good *quality* of care. *See* 42 U.S.C. §§ 1396n(a)(2)(B), (b)(1)-(2), (i)(1)(H)(i) (conditioning federal money on the quality of care); *id.* at § 1396a(a)(22) (requiring state plans to assure "high quality" medical assistance); *id.* at § 1396a(a)(33)(A) (plans must be reviewed for "appropriateness and quality of care"). Other provisions require plans to provide care with "reasonable promptness." 42 U.S.C. § 1396a(a)(8). And yet another provision requires a review of whether policies help "improve and maintain" an individual's "health and functional status." *Id.* at § 1396(b)(2)(B); *see also* Ark. Br. 24-29. On their face, those provisions go beyond assuring maximum coverage alone.

The D.C. Circuit mostly disregarded these provisions. Instead, it relied primarily on Medicaid's *original* appropriation provision—Section 1901—to find Medicaid's exclusive statutory objective. But that reliance is misplaced. Section 1901 authorizes the appropriation of funds to help states "furnish (1) medical assistances on behalf of families with dependent children and of aged, blind, or disabled 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." 42 U.S.C. § 1396-1; *see* Pet. App. 10a. In light of that provision, the D.C. Circuit held that the Secretary improperly considered heath and independence, rather than coverage alone. *See* Pet. App. 12a. Indeed, it found that there was no "textual support" for the idea that Medicaid has *any* other objective, including "improving health outcomes," "address[ing] behavioral and social factors that influence health outcomes," or "incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes." *See id.*

Remarkably, the D.C. Circuit not only held that expanding coverage was the sole purpose of Medicaid but also that "better health outcomes and beneficiary independence are *not consistent* with Medicaid." *Id.* at 16a. (emphasis added). That badly misses the mark. If Medicaid's sole objective were maximizing eligible beneficiaries' coverage, then—under the court of appeals' reasoning—no experimental work or community-engagement requirement would ever be permissible, thereby stripping states of important tools to promote self-sufficiency and protect program finances.

Moreover, since Section 1901 addresses coverage only for those originally covered under the Medicare program—namely disabled individuals or those with dependents—that provision is of little relevance in addressing Medicaid's massive expansion to able-bodies adults without dependents. By its own terms, Section 1901's "purpose" is limited to helping families with children and the aged, blind, and disabled, *i.e.*,

those who are often unable to care for themselves or be self-sufficient without assistance. But that provision sheds little light on Congress' intent 40 years later when it expanded Medicaid to categories of individuals, such as able-bodied adults without dependents, who *are* capable of self-sufficiency. The D.C. Circuit failed to grapple with the fact that the statutory provision it cited in support of the "sole" statutory purpose has no applicability to the very individuals who would be most directly affected by Arkansas' community engagement requirements. At bottom, there is no support for an interpretation of the program's objectives as a one-way ratchet designed solely to expand coverage to the exclusion of all other objectives or purposes.

There is similarly no support for the court's conclusion that Medicaid does not seek to help people transition off public assistance and live independent lives. The Secretary determined that it "furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means ... to promote beneficiary independence." *Id.* at 75a. The decision below concluded, however, that "reference to 'independence'" in the statute "is in the context of assisting beneficiaries in achieving functional independence through rehabilitative and other services, not financial independence from government welfare programs." *Id.* at 14a-15a.

But the D.C. Circuit offered little analysis in support of that determination, and the appropriation provision itself refutes that conclusion. That very section states that Medicaid exists to help individuals "attain or retain capability for independence or self-

care." 42 U.S.C. § 1396-1. And if "independence" meant only "functional independence," it would make no sense as applied to "families with dependent children" as opposed to the "aged, blind, or disabled." *Id.*; *see also* Ark. Br. 45-46. The Secretary's broader view of the program as promoting health, well-being, and self-sufficiency more generally was eminently reasonable and comfortably within the bounds of the applicable statutes.

The D.C. Circuit's holding also undermines the system of cooperative federalism that is central to Medicaid. Medicaid has embodied cooperative federalism from the beginning. It is a "program ... [that] provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs." *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). And the states work closely with the federal government to formulate and administer plans for eligible recipients.

Given its status as a cooperative federal-state program, Medicaid provides a waiver mechanism that gives states flexibility to adopt programs that best fit each state's circumstances while still advancing Medicaid's goals. Under the waiver mechanism, "the Secretary may waive compliance with any of the requirements" of Medicaid "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of those programs. 42 U.S.C. § 1315(a). This gives states the freedom to experiment with different approaches based on the latest research and the unique conditions in each state. And, as the

Secretary has noted, these projects can "introduc[e] new approaches that can be a model for other States and lead to programmatic changes nationwide." Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. 11,678 (Feb. 27, 2012).

Here, the Secretary reasonably granted Arkansas a waiver for its community engagement program, which aimed to "test whether coupling the requirement for certain beneficiaries to engage in and report work or other community engagement activities with meaningful incentives to encourage compliance will lead to improved health outcomes and greater independence." Pet. App. 68a. The Secretary determined that Arkansas' program "is likely to assist in promoting the objectives of the Medicaid program." *Id.*

Yet the D.C. Circuit halted Arkansas' approved experiment in favor of a one-size-fits-all approach that would foreclose many innovative policy options for Arkansas and other states. That overriding of states' policy choices about how to run one of their largest spending programs raises profound federalism concerns. *See, e.g.*, *NFIB v. Sebelius*, 567 U.S. 519, 588 (2012) (federalism demands that "States must have a genuine choice" when working with the federal government in connection with the Medicaid program). Indeed, if the D.C. Circuit's approach is allowed to stand, countless types of innovative new programs would be jeopardized because they would be ineligible for waivers unless they expanded coverage, full stop.

The D.C. Circuit's unduly narrow interpretation of the objectives of the Medicaid program skewed the rest of the court's analysis as well. In light of the court's focus on coverage as the sole objective of the Medicaid program, the court found that the Secretary acted arbitrarily because he did not provide enough analysis of the waiver's impact on coverage. But once the objectives of the Medicaid program are properly defined, there is no question that the waiver for Arkansas' community-engagement requirements would advance them. *See infra* Section II. At bottom, it was eminently reasonable for HHS to take a broader view of the program as promoting health, well-being, and self-sufficiency more generally, and to allow states to experiment and innovate to advance those goals.

II. Work and community engagement promote good health, well-being, and self-sufficiency and help transition individuals off public assistance programs.

Since the Founding, Congress and the American people have recognized that "the values of work and family … form the foundation of America's communities." H.R. Rep. No. 104-651, at 3 (1996) (discussing Personal Responsibility and Work Opportunity Reconciliation Act of 1996). "[T]he dignity of work and the cherished bonds of stable familial life" have afforded Americans "the power to make something of themselves." *United States v. Taylor*, 784 F. App'x 145, 160 (4th Cir. 2019). And for nearly 250 years, the government has "empower[ed] States and local communities" to help individuals—

especially the poor—find work. *See* H.R. Rep. No. 104-651, at 6 (1996).

There can be no serious dispute about the fundamental importance of meaningful work. As the U.S. government has long recognized, all American "citizens should have the opportunity to live and work with dignity." Proclamation No. 7600, 67 Fed. Reg. 62167 (Oct. 1, 2002). That is because there is "dignity" and "power" in the "ethic of work." *See President Clinton's Statement on Signing PRWORA*, 32 Weekly Comp. Pres. Doc. 1325 (Aug. 22, 1996). Considering how "central" work is "to the nation's economic and social organization," it makes sense that "work is … a central feature of government benefit programs" too. Cong. Research Serv., R43400, *Work Requirements, Time Limits, and Work Incentives in TANF, SNAP, and Housing Assistance* 2 (2016) ("CRS 2016 Report"). Indeed, "[t]he largest benefit programs … such as Social Security, Medicare, and Unemployment Insurance," all provide benefits that are "earned through work." *Id*.

Like all important values, "work … ought to be encouraged." H.R. Rep. No. 104-651, at 4 (1996). It transitions welfare "recipients [from] a cycle of dependency," to a life of "responsibility, and self-sufficiency." *Id.* at 3-4. That is why Congress, the Department of Health and Human Services, and the Centers for Medicare and Medicaid Services have all acknowledged for decades that the government has a "duty to engage [able-bodied] adults and help put them back on the path to self-sufficiency" through the dignity of "work." *Examining The Proposed ABAWD Rule And Its Impact On Hunger And Hardship*,

Hearing Before The Subcomm. On Nutrition, Oversight, And Dep't Operations Of The Comm. On Agric. H.R., 116th Cong. 21 (2019). Simply put, promoting work is "the right thing to do for our people, just as it's the right thing to do for American taxpayers." *See Medicare and Medicaid Guide Letter*, No. 1985 (Apr. 24, 2018).

Promoting meaningful work is also the right thing to do for those in need. As Congress has acknowledged—and numerous studies have confirmed—"people who have climbed up out of welfare and stepped up into the workplace are leading fuller, more satisfying lives." 149 Cong. Rec. 465, 529 (2003) (statement of Rep. DeLay). A steady job fosters stable communities and "promote[s] a culture of work rather than one of dependency." CRS 2016 Report at 3. Work provides safer streets, stronger families, and healthier children. *See* H.R. Rep. No. 104-651, at 4-5 (1996). So it should be no surprise that tethering work and community engagement to public assistance produces similar benefits.

A. Extensive research shows the benefits of work and community engagement requirements in connection with public assistance programs.

A growing body of research supports the common-sense conclusion that, "without income from work, a person and his or her family members are almost certain to be poor." CRS 2016 Report at 3. This explains why "9 in 10" "families without a worker … [a]re classified as poor" while only "13.5% of all persons were officially in poverty." *Id.* at 26. Indeed,

"work is almost always necessary for a family to advance." *Id.* at 3-4. And it "is effectively the only route out of poverty." *Id.* at 3. Without work, "a person and his or her family" are "almost always relegate[d] … to poverty." *Id.*

By tying work and community engagement to public assistance, the government can help break the cycle of poverty. Consider Temporary Assistance to Needy Families (TANF)—a bipartisan welfare program mandating modest work-requirements for able-bodied adults. Soon after Congress passed TANF, "the cash assistance caseload declined substantially" and program participants started leaving welfare in droves. *See id.* at 1. TANF helped move "families [off] the rolls more quickly" than traditional welfare and led to "a decline in the number of families entering the program." *Id.*

TANF saw remarkable results, "helping millions of individuals out of the welfare trap and leading to higher incomes." Nicholas Horton, *The Future Of Medicaid Reform: Empowering Individuals Through Work*, Found. for Gov't Accountability (Nov. 14, 2017), bit.ly/3nAvRWT. Indeed, "[f]ollowing enactment of … [TANF], the number of families with children receiving cash assistance declined dramatically, employment of single mothers increased, and poverty among children declined." CRS 2016 Report at 1.

And TANF is not an outlier. Studies show that states that implement work-requirements raise incomes and improve outcomes. "When able-bodied adults on welfare have work requirements, they go back to work in more than 600 different industries and

earn twice as much as they did when they were on welfare." Nicholas Horton, *Work requirements are working for Kansas families: How welfare reform increases incomes and improves lives*, Found. for Gov't Accountability (Jul. 31, 2017), bit.ly/3i5sdTV. After Maine implemented work requirements for its public assistance program, incomes of former enrollees doubled. *See* Sam Adolphsen, *There has never been a better time for welfare reform*, Found. for Gov't Accountability (June 13, 2018), bit.ly/2K4BG0X. In Kansas, individuals who left welfare for work similarly saw their incomes "more than double." Jonathan Bain, *Food Stamp Work Requirements Worked For Missourians*, Found. for Gov't Accountability (Oct. 19, 2020), bit.ly/39kT2zr. And, in Missouri, able-bodied adults who were subject to the state's work requirements saw their wages rise by 70 percent within three months of leaving welfare. *See id.* Over time, Missourians' incomes grew even more, eventually doubling. *See id.* "This sharp rise in income more than offset … lost welfare benefits." *Id.*

Arkansas' results were even more impressive. After Arkansas adopted reforms designed to promote work in connection with the original Arkansas Works demonstration program, Arkansans who returned to work saw their incomes triple in less than three years. *See* Nicholas Horton, *Work requirements are working in Arkansas: How commonsense welfare reform is improving Arkansas' lives*, Found. for Gov't Accountability (Jan. 9, 2019), bit.ly/2LL7mc4.

Yet moving from dependency to self-sufficiency does more than just increase monetary income. A growing body of research shows that returning to

work also helps remedy poor health. Numerous studies confirm that joblessness "results in sharply increased mortality for US workers." Jessamyn Schaller, *Short-run effects of job loss on health conditions, health insurance, and health care utilization*, 43 J. Health Econ. 190, 191 (2015). And chronic unemployment "brings with it long-lasting reductions … [i]n the health and well-being of individuals and their families." *Id.* at 201. The lack of a job "is associated with significant declines in self-rated physical and mental health … and increased reports of anxiety or depression." *Id.*

Other studies paint an even grimmer picture. According to Daniel Sullivan of the Federal Reserve Bank of Chicago, the jobless "are 10-15% more likely to die in the two decades following" the loss of their last job. *Id.* (citing Daniel Sullivan, *Job displacement and mortality: an analysis using administrative data*, 124 Q. J. of Econ. 1265-1306 (2009)). The best solution to these maladies is a job—and community engagement requirements such as the ones the D.C. Circuit invalidated provide welfare recipients with the right encouragement and incentives to transition from dependency to meaningful work.

B. Pilot programs like Arkansas' are even more imperative given the severe impact that Medicaid spending is having on state and federal budgets.

Work and community engagement requirements do not just promote self-sufficiency and better health; they also steward scarce resources and ensure program funding remains available to the most

vulnerable. Since Medicaid is responsible for a massive and growing share of state budgets, it is imperative for states to have the flexibility to adopt innovative policies that will improve wellbeing and help transition beneficiaries off public assistance.

For more than two decades, Medicaid spending has rapidly increased, with no sign of slowing down. In 2000, Medicaid expenditures were $206 billion. Less than ten years later, in 2009, Medicaid spending had increased over 60%, surpassing $327 billion. *See* Nick Samuels, *2000 State Expenditure Report*, Nat'l Ass'n of State Budget Officers (June 2001), bit.ly/3i5xHOv. Since then, Medicaid spending has continued to skyrocket, topping $633 billion in 2018. *See* Nicholas Horton, *The Future Of Medicaid Reform: Empowering Individuals Through Work*, Found. for Gov't Accountability (Nov. 14, 2017), bit.ly/3nAvRWT. To put that in perspective, Medicaid spending in the United States is now larger than the economies of several European countries, including Sweden, Poland, and Belgium. *See* Nicholas Horton, *How Medicaid Is Consuming State Budgets*, Found. for Gov't Accountability (Oct. 29, 2019), bit.ly/38F0ypP.

Even more concerning is the cost of Medicaid spending *tomorrow*. Within five years, Medicaid spending is projected to exceed more than $1 trillion per year. *See id.* And "[o]ver the next decade, Medicaid spending is projected to outpace economic growth." *See* Ctr. for Medicare and Medicaid Servs., *2017 Actuarial Report on the Financial Outlook for Medicaid* (Dep't of Health and Hum. Servs., 2017). To make matters worse, "Medicaid spending is not just growing quickly—it is growing faster than state

revenues and faster than any other line-item in state budgets." Nicholas Horton, *The Future Of Medicaid Reform: Empowering Individuals Through Work*, Found. for Gov't Accountability (Nov. 14, 2017), bit.ly/3nAvRWT. The increase in Medicaid spending on able-bodied adults alone is shocking. Since 2000, total "spending on able-bodied adults has increased by a jaw-dropping 700 percent." *Id.*

Medicaid's spending growth is unsustainable—and is crowding out spending for other vital state programs. In 1987, "Medicaid represented about 10.2 percent of all State expenditures." H.R. Rep. No. 104-651, at 8 (1996). By 1994, Medicaid spending "had increased to about 19.4 percent." *Id.* At the turn of the century, just five states reported that more than 25 percent of their budgets went to Medicaid. *See* Nicholas Horton, *How Medicaid Is Consuming State Budgets*, Found. for Gov't Accountability (Oct. 29, 2019), bit.ly/38F0ypP.

The landscape looks much different today: "Medicaid is now consuming 30 percent of state budgets, devouring nearly one out of every three dollars states spend." *Id.* Since 2000, "47 states have seen Medicaid grow as a share of their budgets." *Id.* And "[t]hirty-two states now have a quarter or more of their budgets devoted solely to Medicaid spending." *Id.* In some states—such as Missouri, Ohio, and Pennsylvania—Medicaid spending accounts for two out of every five dollars of state revenue. See *id.*

Medicaid's unprecedented spending surge leaves fewer resources for other budget priorities, including education, public safety, and infrastructure. Take

Ohio, for example. In 2000, Ohio's Medicaid budget was roughly $7.3 billion. *See* Nick Samuels, *2000 State Expenditure Report*, Nat'l Ass'n of State Budget Officers (June 2001), bit.ly/3i5xHOv. This represented about 19 percent of the state's entire budget, consistent with the national average at the time. *See id.* Fast forward to 2018 and Ohio's Medicaid program is almost unrecognizable. The program now costs taxpayers nearly $27 billion per year—more than the state's entire general revenue in 2000—and consumes 38 percent of the state budget. *See id.*

Alaska has faced similar problems. In 2000, Alaska devoted just 10 percent of its budget to Medicaid—a figure well below the national average. *See* Nick Samuels, *2000 State Expenditure Report*, Nat'l Ass'n of State Budget Officers (June 2001), bit.ly/3i5xHOv. By 2018, that figure had doubled, with Medicaid consuming 21 percent of the state's budget. *See* Brian Sigritz, *2018 State Expenditure Report*, Nat'l Ass'n of State Budget Officers (2018), bit.ly/2MXuqFl. During the same time, Alaska's total Medicaid spending nearly quintupled, increasing by a staggering 379 percent and growing 25 times as fast as state revenues. *See* Nicholas Horton, *How Medicaid Is Consuming State Budgets*, Found. for Gov't Accountability (Oct. 29, 2019), bit.ly/38F0ypP.

Indiana's Medicaid problems are even worse. In 2000, Indiana's Medicaid budget was just under $3 billion and accounted for less than 18 percent of total state spending. *See* Nick Samuels, *2000 State Expenditure Report*, Nat'l Ass'n of State Budget Officers (June 2001), bit.ly/3i5xHOv. Nine years later, spending nearly doubled, topping out at $5.6 billion,

or 22 percent of state spending. *See* Brian Sigritz, *State Expenditure Report: Fiscal Year 2009*, Nat'l Ass'n of State Budget Officers (2010), bit.ly/2MV8CKy. Since 2009, Indiana's Medicaid spending has nearly doubled again, coming in at more than $11.6 billion—an increase of 292 percent since 2000. *See* Brian Sigritz, *2018 State Expenditure Report*, Nat'l Ass'n of State Budget Officers (2018), bit.ly/2MXuqFl. This unsustainable growth rate has eaten away at many other important state priorities. *See, e.g.*, Robert Toutkoushian, *Education Funding and Teacher Compensation In Indiana: Evaluation and Recommendations*, Ind. State Tchr. Ass'n (Mar. 11, 2019), bit.ly/3oB5amf.

Spending on able-bodied adults is one of the key drivers of Medicaid's unsustainable price tag. Today, nearly 75 million individuals are enrolled in Medicaid—more than twice as many as in 2000. *See* Nicholas Horton, *The Future Of Medicaid Reform: Empowering Individuals Through Work*, Found. for Gov't Accountability (Nov. 14, 2017), bit.ly/3nAvRWT. Nearly 28 million are able-bodied adults, up from fewer than 7 million in 2000. *See id.* In the last twenty years, the share of able-bodied adults on Medicaid has more than doubled, increasing from one out of five recipients to nearly 40% of Medicaid beneficiaries. *See id.* This has predictably led to skyrocketing costs. Since 2000, spending on able-bodied adults has increased from just $19 billion to nearly $158 billion—an increase of more than 700 percent. *See id.*

Despite the fact that Medicaid's able-bodied adults have no physical disabilities keeping them from pursuing gainful employment, very few actually

work full-time. *See id.* According to the Census Bureau, most non-disabled adults on Medicaid do not work at all. *See id.* In Michigan, half of all able-bodied adults are not working. *See id.* In Illinois, 54 percent of able-bodied adults report no income. *See id.* In Ohio, 57 percent of able-bodied adults enrolled in the Affordable Care Act's Medicaid expansion are not working. *See id.* In New Hampshire, 58 percent of enrollees do not work at all. *See id.* And in Nevada, a staggering 60 percent of enrollees report no income. *See id.*

Medicaid's excessive and unchecked spending—especially on able-bodied individuals without dependents—is straining the resources available for those truly in need. Naturally, "the extension of assistance to cases where [people are] capable of earning money [] diminish[es] the funds available for cases where they [are] not." *Aguayo v. Richardson*, 473 F.2d 1090, 1104 (2d Cir. 1973) (Friendly, J.). Nationwide, "there are more than 650,000 individuals on Medicaid waiting lists" for vital home- and community-based care. *See* Nicholas Horton, *Waiting For Help: The Medicaid Waiting List Crisis,* Found. for Gov't Accountability (Mar. 6, 2018), bit.ly/3ozOOdu. And many wait-list participants are Medicaid's most vulnerable—those suffering from severe intellectual disabilities, traumatic brain injuries, mental illnesses, and other debilitating conditions. *See id.*

These individuals often wait years for treatment. According to one study, "[t]hree-quarters of states reported [having] waiting lists" for essential Medicaid services. *See* Mary O'Malley, *Medicaid home and community-based services: Results from a 50-state*

survey of enrollment, spending, and program policies, Kaiser Family Found. (Jan. 3, 2018), bit.ly/3nCHnRo. And in some states, "the average wait time for an individual … is *seven years and six months*." Nicholas Horton, *Waiting For Help: The Medicaid Waiting List Crisis,* Found. for Gov't Accountability (Mar. 6, 2018), bit.ly/3ozOOdu (emphasis added). The consequences of these long waiting times are dire: In the last eight years, more than 21,904 individuals have died while languishing on Medicaid's waiting lists. *See id.*

Arkansas is not immune from these problems, as the state's waiting list is currently more than 3,200 people long (and growing). *See id.* Even though Arkansas has made significant strides towards reducing its waiting list, eliminating the state's Medicaid backlog "will only be possible with adequate funding." Nicholas Horton, *Arkansas' Medicaid work requirement was working*, Found. for Gov't Accountability (May 14, 2019), bit.ly/2MZ00mh. But Medicaid spending—especially spending on able-bodied adults—is currently out of control.

To temper the unchecked and unsustainable spending on able-bodied Medicaid recipients, it is imperative for states to have the flexibility to adopt innovative policies that will improve wellbeing and help transition beneficiaries off public assistance. A number of states have *already* demonstrated that work and community engagement requirements can be an important part of the solution to runaway spending on public benefit programs.

After Missouri restored work requirements for the state's food stamp program, spending declined and tax

revenue soared. Less than a year after Missouri implemented these common-sense reforms, spending on able-bodied recipients fell from $114 million to "just $15 million." Jonathan Bain, *Food Stamp Work Requirements Worked For Missourians*, Found. for Gov't Accountability (Oct. 19, 2020), bit.ly/39kT2zr. As thousands of Missourians transitioned from welfare to work, "state income tax revenue climbed by an estimated $12 million per year." *Id.* In total, Missouri's program was able to target more than $100 million in additional funding to the state's poorest and most vulnerable. *See id.*

After Maine instituted work requirements in 2014, thousands of able-bodied adults quickly moved from dependency to self-sufficiency. *See* Jonathan Ingram, *New Report Proves Maine's Welfare Reforms Are Working*, Found. for Gov't Accountability (May 19, 2016), bit.ly/2MV2Mc6. By January 2015, the number of able-bodied adults on food stamps had dropped to 4,500—and by May 2016, only "1,500 able-bodied childless adults" relied on Maine's food stamp program. *See id.* Even among those who stayed on the program, incomes rose and "average benefits dropp[ed] 13%." *Id.* In total, Maine "taxpayers sav[ed] between $30 million and $40 million each year." *Id.*

In short, innovative programs designed to promote work and community engagement have saved millions of dollars and lifted tens of thousands out of poverty. And this is just the beginning: If every state implemented Medicaid work requirements for able-bodied adults, "taxpayers could save nearly $1 trillion over ten years." *Work Requirements for*

Medicaid, Found. for Gov't Accountability (2019), bit.ly/2KbWdRu.

C. Arkansas' pilot program reflects good policy based on sound research and has already produced impressive results.

Arkansas has already reaped the benefits of its community engagement pilot program. Since 2013, Arkansas' "total Medicaid budget has exploded … increasing by nearly 60 percent." Nicholas Horton, *Arkansas' Medicaid work requirement was working*, Found. for Gov't Accountability (May 14, 2019), bit.ly/2MZ00mh. As a result, Arkansas' Medicaid program has cost taxpayers nearly $1 billion more than promised. *See id.* As enrollment soared, Medicaid spending began eclipsing and crowding out other important budget priorities. *See id*. (noting that "[t]otal Medicaid spending in Arkansas is now more than double the state's entire education budget"). And, because of unsustainable Medicaid costs, Arkansas continues to "maintain[] a waiting list for home and community-based Medicaid services." *Id.*

When forced to cut back on vital state services to support the state's budget for able-bodied Medicaid recipients, Arkansas implemented a package of critical reforms: it began requiring able-bodied adults on Medicaid to work, look for work, seek education or job training, or volunteer. The results were promising. Before the district court halted the program, Arkansas had been incredibly successful at moving able-bodied adults to independence. When it first implemented these requirements, more than 287,000 adults were enrolled in the state's Medicaid

expansion. *See id*. Less than a year later, enrollment among able-bodied adults "had declined to 247,000—a drop of nearly 14 percent." *Id*.

Transitioning Arkansans off Medicaid and into work has already paid impressive dividends. The declining number of able-bodied Arkansans on Medicaid has "created savings for taxpayers"—and by the end of 2018, "Arkansas was on track to save taxpayers at least $300 million per year." *Id.* That is "more than enough to fully eliminate the state's Medicaid waiting list." *Id.*

It is unsurprising that the program was working. Arkansas based its policy on sound research demonstrating that work and community engagement requirements are an effective tool to combat poverty. And the Secretary similarly analyzed and applied sound research when deciding to approve Arkansas' program. In the end, welfare programs "too often hurt those [they are] supposed to help" by becoming, not "a second chance," but "a way of life." *President Clinton's Statement on Signing PRWORA*, 32 Weekly Comp. Pres. Doc. 1325 (Aug. 22, 1996). Work and community engagement requirements, by contrast, allow states to transition able-bodied, working-age adults off Medicaid, thereby improving their heath and overall well-being while preserving scarce program resources.

III. The COVID-19 pandemic and economic contraction further underscore the importance of pilot programs like Arkansas'.

Respondents and their *amici* will likely argue that the COVID-19 pandemic and associated job losses

show why Arkansas' pilot project is arbitrary, unlawful, or just bad policy. But that is exactly backwards. The Arkansas program allows compliance not only through work itself but also by looking for work, engaging in job training, seeking education, or volunteering. Thus, even for individuals impacted by COVID-19 or job loss, there is significant flexibility to ensure that they are engaging in activities that will keep them involved in the community and improve their skills for the future. The pandemic and economic contraction make policies like this more important, not less.

The COVID-19 pandemic has taken its toll on individuals in countless ways and has resulted in increased unemployment. But Arkansas' project is flexible enough to account for these unprecedented circumstances. To avoid coverage loss, Arkansas' program offers a number of alternatives for those truly unable to secure work. As Petitioners explain, Arkansas "carefully designed" its program so that its work requirement "was attainable and could be complied with in a variety of ways." Ark. Pet. 6. While it is undoubtably more difficult to find a job given the current economic circumstances, participants can meet the relevant requirements through community engagement efforts, including attending educational programs (like GED classes), receiving vocational or job skills training, or volunteering in their community. *See* Pet. App. 114a. That flexibility not only allows participants to fulfill the community engagement requirement, but also helps stave off the other adverse health issues the pandemic has caused.

Scholars have recently found that, despite the current hardship in finding employment, "the community-engagement aspects of [work requirement] proposals" like "volunteering and schooling ... remain relevant." Christopher Brown, *Coronavirus Crisis Stirs Fresh Debate Over Medicaid Work Rules*, Bloomberg Law (Apr. 21, 2020), bit.ly/2LGo10J (quoting Rea Headerman, VP of Policy, The Buckeye Institute). "Research on unemployment shows that losing one's job is detrimental to mental health—and often physical health—even without serious financial strain." Stephanie Pappas, *The Toll of Job Loss*, Am. Psychological Ass'n (Oct. 1, 2020), bit.ly/3q8uGzz. And along with job losses, the COVID-19 pandemic saw "[e]levated levels of mental health conditions, substance use, and suicidal ideation." *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic,* Ctrs. for Disease Control (Aug. 14, 2020), bit.ly/2K5jgxe. That is unsurprising given that "unemployment is linked to anxiety, depression and loss of life satisfaction, among other negative outcomes." Stephanie Pappas, *The Toll of Job Loss*, Am. Psychological Ass'n (Oct. 1, 2020), bit.ly/3q8uGzz. Accordingly, people who have jobs or meaningful alternatives are significantly better off. *See supra* Section II. That includes engaging in activities that will improve their education or skills for future jobs or keep them involved in their communities—activities like those provided in Arkansas' pilot program.

Job search programs, for example, provide one way to meet Arkansas' requirement. Not only do these programs teach "job seekers how to network, find

appropriate openings and apply to them," but some emphasize "skill development and motivation enhancement," which can include "building participants' confidence and us[ing] discussion, role-playing and positive feedback to practice job search skills." Stephanie Pappas, *The Toll of Job Loss*, Am. Psychological Ass'n (Oct. 1, 2020), bit.ly/3q8uGzz. Those efforts can, in turn, "improve reemployment and mental health in participants," *id.*, and prepare them to reenter the work force even if they are not able to find a job immediately.

Job training or education is yet another means to fulfill Arkansas' requirement. Scholars have noted that, despite the pandemic, it is "still urgent" to "equip[] workers with the skills that will be demanded in the labor market in coming years." Kristen E. Broady, et al., *Preparing U.S. Workers for the Post-COVID Economy; Higher Education, Workforce Training, and Labor Unions*, Brooking Inst. (Dec. 16, 2020), brook.gs/3sbpn4c. Indeed, the "COVID-19 pandemic has accelerated the need for improvements in ... worker training." *Id.* Especially given that "a greater share of jobs in the future will likely require telepresence," new and better job skills are critical. *Id.*; *see also* Kate Lister, *Work-At-Home After Covid-19—Our Forecast*, Glob. Workplace Analytics (last accessed Jan. 10, 2021), bit.ly/3owvcqQ (estimating that after the pandemic has subsided, 30% of the workforce will be working from home).

Volunteering, too, "is associated with better employment and health outcomes" in the long run. *Volunteers Are in Better Heath Than Non-Volunteers*, Ghent Univ. (Mar. 9, 2017), bit.ly/39js2QN; *see also*

Pet. App. 61a-65a (collecting studies). Studies show that those who spend time volunteering "are substantially in better heath than non-volunteers." *Id.* Volunteering can help with self-esteem, self-efficiency, and social integration, and helps promote physical and cognitive activity—all of which advance an individual's heath. *Id.* In fact, the "direct association between volunteering and health" is so "highly statistically significant" that it "rule[s] out that this association is occurring by coincidence." *Id.*

At bottom, neither COVID-19 nor the economic contraction render Arkansas' waiver arbitrary or unlawful. And neither change the fact that Arkansas' project is good policy. As former Speaker of the House Paul Ryan explained, "[w]e don't want to turn the safety net into a hammock that lulls able-bodies people to lives of dependency and complacency, that drains them of their will and their incentive to make the most of their lives." Arthur Delaney et al., *Paul Ryan Wants 'Welfare Reform Round 2'*, HuffPost (Mar. 20, 2012), bit.ly/3bmbF8K. To the contrary, social welfare programs must include mechanisms to help able-bodied individuals get back on their feet and live independent, healthy, and fulfilling lives. Arkansas' program—which provides significant flexibility for participants—will help do just that, and the courts below erred by enjoining this critically important initiative.

CONCLUSION

For the foregoing reasons, the Court should reverse the decision below.

Respectfully submitted,

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