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.

STATE OF ARKANSAS,
Petitioner,
v.
CHARLES GRESHAM, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF FOR PETITIONERS

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QUESTION PRESENTED

The question presented is:

Whether the Secretary's approval of the Arkansas Works Amendment was lawful.

PARTIES TO THE PROCEEDING BELOW

Petitioners in No. 20-37 are Alex M. Azar II, in his official capacity as the Secretary of Health and Human Services; Seema Verma, in her official capacity as the Administrator of the Centers for Medicare and Medicaid Services; the United States Department of Health and Human Services; and the Centers for Medicare and Medicaid Services—all of which were defendant-appellants in the court of appeals in Nos. 19-5094 and 19-5293, and defendant-appellees in the court of appeals in Nos. 19-5096 and 19-5295.

Petitioner in No. 20-38 is the State of Arkansas, which was an intervenor-appellant in the court of appeals in 19-5096.

Respondents in No. 20-37 are Charles Gresham, Cesar Ardon, Marisol Ardon, Adrian McGonigal, Veronica Watson, Treda Robinson, Anna Book, Russell Cook, and Jamie Deyo, who were plaintiff-appellees in the court of appeals in Nos. 19-5094 and 19-5096; Samuel Philbrick, Ian Ludders, Karin Vlk, and Joshua Vlk, who were plaintiff-appellees in the court of appeals in Nos. 19-5293 and 19-5295; the New Hampshire Department of Health and Human Services, which was an intervenor-appellant in the court of appeals in No. 19-5295; and the State of Arkansas.

Respondents in No. 20-38 are Charles Gresham, Cesar Ardon, Marisol Ardon, Adrian McGonigal, Veronica Watson, Treda Robinson, Anna Book, Russell Cook, and Jamie Deyo; Alex M. Azar II, in his official capacity as the Secretary of Health and Human Services; Seema Verma, in her official capacity as the Administrator of the Centers for Medicare and Medicaid Services; the United States Department of Health and Human Services; and the Centers for Medicare and Medicaid Services.

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The court of appeals' opinion (Pet.App. 1a-20a) is reported at 950 F.3d 93. The district court's order (Pet.App. 21a-60a) is reported at 363 F. Supp. 3d 165.

JURISDICTION

The court of appeals entered judgment on February 14, 2020. The petition was timely filed on July 13, 2020. This Court granted the petition on December 4, 2020, and has jurisdiction under 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The "Demonstration projects" section of the Social Security Act, 42 U.S.C. 1315, is set forth in the appendix to this brief at 1a-9a. The "Appropriations" section of Subchapter XIX of the Social Security Act, 42 U.S.C. 1396-1, is set forth in the appendix to this brief at 10a.

STATEMENT

I. Statutory Background.

A. The Medicaid Program.

In 1965, Congress enacted Medicaid to provide health care coverage to four categories of medically needy people: the disabled, the blind, the elderly, and needy families with dependent children. *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 583 (2012). From its inception, Medicaid has been a cooperative federalism program. States administer the program under plans approved by the Secretary, 42 U.S.C. 1396a(b), and in return, States receive federal funding. 42 U.S.C. 1396b. Every State participates in Medicaid. *NFIB*, 567 U.S. at 542.

In the decades after Medicaid's enactment, Congress slowly expanded Medicaid eligibility to include other especially needy groups, principally adding pregnant women and increasing the number of eligible children. *Id.* at 585.

But in 2010, Congress "transformed" Medicaid, turning it from "a program to care for the neediest among us" into one that met "the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *Id.* at 583. Enacted as part of the Affordable Care Act's effort to provide more widespread access to health care, what became known as the Medicaid expansion not only made that population eligible, but conditioned State participation in pre-expansion Medicaid on covering it. *Id.* at 542. In *NFIB*, this Court reasoned that the expansion was "a new health care program"—not "a mere alteration of [the] existing" one—and held that condition unconstitutionally coercive. *Id.* at 584-85.

As a result, a State's participation in the Medicaid expansion is voluntary. *Id.* at 585. And many States have opted not to participate. *See Status of State Action on the Medicaid Expansion Decision*, Kaiser Fam. Found. (Nov. 2, 2020).[1]

B. Demonstration Projects

In 1962, concerned that the Social Security Act's detailed state plan requirements "often st[oo]d in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients," S. Rep. No. 87-1589, at 19 (1962) (Conf. Rep.), Congress enacted Section 1115 of the

[1] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

Social Security Act. Public Welfare Amendments of 1962, Pub. L. No. 87-543, sec. 122, 76. Stat. 172, 192 (1962) (codified as amended at 42 U.S.C. 1315). That section grants States leeway to experiment by empowering the Secretary to "waive compliance with any of the requirements" of a host of State-administered public-assistance programs, including 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).

1. Demonstration projects do not just afford the States administering them freedom to experiment; they "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, 11678 (Feb. 27, 2012). For example, decades before Congress imposed work requirements as part of comprehensive welfare reform, States used Section 1115 demonstration projects to experiment with similar requirements. *See Aguayo v. Richardson*, 473 F.2d 1090, 1093-96 (2d Cir. 1973) (Friendly, J.) (upholding such a project); Anthony Albanese, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today*, 128 Yale L.J. Forum 827, 833-34 (2019) (describing these "precursor[s]" to welfare reform under the first Bush, and Clinton, administrations).

In fact, the Medicaid expansion itself began as a series of demonstration projects that extended Medicaid coverage to then-ineligible populations. *See Spry v. Thompson*, 487 F.3d 1272, 1274-75 (9th Cir. 2007) ("States may also create 'experimental, pilot or demonstration' projects to serve 'expansion populations'—

individuals who . . . [receive benefits] only because of the Secretary's waiver."). The Massachusetts program that inspired the ACA's individual mandate and exchanges was such a project. Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 Stan. L. Rev. 1689, 1722 (2018).

But Section 1115 hasn't only been used to expand coverage. Instead, as the Obama administration explained, Section 1115 has also long been used to test whether "constrain[ing] eligibility or benefits in ways not otherwise permitted by statute" might further Medicaid's objectives, Medicaid Program; Review and Approval Process for Section 1115 Demonstrations. 77 Fed. Reg. at 11678. And Congress has embraced those efforts.

As early as the 1970s, for example, the Secretary allowed States to experiment with co-pays, testing whether they could conserve Medicaid costs and deter overuse of unnecessary services. *See, e.g.*, *Cal. Welfare Rts. Org. v. Richardson*, 348 F. Supp. 491, 495 & n.3, 498 (N.D. Cal. 1972) (upholding such a waiver). After "a large number of States . . . sought [such] waivers," H.R. Rep. No. 97-757, pt. 1, at 6 (1982), Congress amended Medicaid to permit co-pays for some beneficiaries and services. It also tellingly authorized the Secretary to continue granting time-limited waivers for others that he found would "provide benefits to [beneficiaries] which can be reasonably expected to be equivalent to the[ir] risks." 42 U.S.C. 1396*o*(f)(3).

Furthermore, because longstanding Office of Management and Budget guidance required waivers to be budget neutral, even so-called expansion waivers had to be paired with limitations on coverage for others. *See* Albanese, *supra*, at 833, 835 (discussing guidance dating back to the Reagan administration). Consequently,

many of the expansion waivers approved during the second Bush administrationwere financed by increased beneficiary cost-sharing, leaner benefits, and enrollment caps. *Id.* at 835; *The New Medicaid and CHIP Waiver Initiatives*, Kaiser Comm'n on Medicaid and the Uninsured 19-24 (February 2002).[2]

Those coverage cuts had their critics, and the ACA might have been expected to disapprove them. Instead, in enacting the ACA, Congress expressly acknowledged that Section 1115 waivers that "result in an impact on eligibility, enrollment, benefits, [or] cost-sharing" could "promote the objectives of [Medicaid and SCHIP]." 42 U.S.C. 1315(d)(1). And rather than bar such waivers, the ACA merely imposed a requirement that those kinds of waivers go through the heightened notice-and-comment procedure employed in this case. *Id.*

Then, after *NFIB* concluded that States could not be compelled to participate in Medicaid expansion, many States sought—and the Obama administration approved—Section 1115 waivers in their Medicaid expansion programs, designed to test better ways of allocating limited resources and meeting the needs of their citizens. As before, those waivers allowed States to experiment with different forms of cost-sharing (including conditioning enrollment on paying premiums), benefits packages that differed from the statutory requirements, and programs that enrolled beneficiaries in private insurance. Gluck & Huberfeld, *supra*, at 1737-40. And in approval after approval, the Obama administration concluded those programs would deter wasteful care, promote personal responsibility, and help transition beneficiaries to ACA exchanges. *See*

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[2] https://www.kff.org/wp-content/uploads/2013/01/the-new-medicaid-and-chip-waiver-initiatives-background-paper.pdf.

Laura D. Hermer, *What to Expect When You're Expecting . . . TANF-Style Medicaid Waivers*, 27 Annals Health L. 37, 48 n.64 (2018) (collecting approvals).

2. Today, Section 1115 Medicaid waivers come in a variety of additional forms. Yet all share the ultimate objective of promoting beneficiary health.

Dozens of waivers, for instance, authorize States to cover services the Medicaid statute specifically *excludes*, testing the hypothesis that those services will improve beneficiaries' health and reduce expenditures on traditional Medicaid services. *See, e.g.*, SMD # 17-003, Ctrs. for Medicare & Medicaid Servs. 3-4 (Nov. 1, 2017) (explaining that substance abuse treatment in mental-health institutions, where Medicaid statutorily excludes coverage, enhances beneficiary health and reduces Medicaid spending on comorbidities).[3]

Others are designed to promote beneficiaries' behavioral health by authorizing States to offer job coaching and tenancy support services, which help beneficiaries resolve landlord-tenant disputes and counsel them on "being a good tenant." CMCS Informational Bulletin, Ctrs. for Medicare & Medicaid Servs. 4 (June 26, 2015);[4] *see Key Themes in Medicaid Section 1115 Behavioral Health Waivers*, Kaiser Fam. Found. 5 (November 2017).[5]

Some waivers depart from the model of health care coverage altogether, offering avowedly "non-medical care" that targets important social and environmental

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[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf.

[5] http://files.kff.org/attachment/Issue-Brief-Key-Themes-in-Medicaid-Section-1115-Behavioral-Health-Waivers.

determinants to health. Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Dave Richard, Deputy Secretary for Med. Assistance, N.C. Dep't of Health & Hum. Servs. 3 (Oct. 19, 2018).[6] Such care includes remediating mold and pest infestations in beneficiaries' homes, providing food and transportation assistance, and offering temporary housing for domestic violence victims. *See* N.C. Medicaid Reform Demonstration, Special Terms and Conditions, Ctrs. for Medicare & Medicaid Servs. 69-71 (Oct. 19, 2018).[7]

And still other waivers provide incentives for behaviors that promote good health—rather than providing services that address the causes of ill health. Indeed, between them, the Bush, Obama and Trump administrations granted 12 States waivers to test healthy-behavior incentives. *See Current Evidence on Healthy Behavior Incentives in the Medicaid Program*, Duke Margolis Ctr. for Health Pol'y 2;[8] *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, Kaiser Fam. Found. (Jan. 11, 2021) ("*Medicaid Waiver Tracker*").[9] Those incentives typically take the form of decreased co-pays for beneficiaries who do things like quit smoking, lose weight, or get annual check-ups. *See The Use of Healthy Behavior Incentives in Medicaid*, Medicaid & CHIP Payment & Access

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[6] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf.

[7] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf.

[8] https://healthpolicy.duke.edu/publications/current-evidence-health-behavior-incentives-medicaid-program.

[9] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state.

Comm'n 2, 4-5 (August 2016).[10] Others, like many private insurance policies, impose premium surcharges if a beneficiary smokes. *See, e.g.*, Healthy Indiana Plan Special Terms and Conditions, Ctrs. for Medicare & Medicaid Servs. 7 (Dec. 9, 2020).[11]

Finally, building on its and its predecessors' experiments with healthy behavior incentives, the Trump administration approved community-engagement requirements in 10 States. *See Medicaid Waiver Tracker*. Based on social science findings that work and volunteering have powerful positive health effects, these demonstration projects condition able-bodied expansion beneficiaries' coverage on community engagement. Those projects, including the Arkansas and New Hampshire projects at issue here, test the hypothesis that doing so will incentivize engagement, improve beneficiaries' health, and help them transition to other coverage.

II. Arkansas Works

In 2013, Arkansas became the first State in the country to receive a Section 1115 waiver to implement the Medicaid expansion. Gluck & Huberfeld, *supra*, at 1737. Rather than enrolling beneficiaries in traditional Medicaid, Arkansas enrolled beneficiaries in private insurance plans, with the State paying the premiums. *See* Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Hum. Servs. 1 (Sept. 27, 2013).[12]

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[10] https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf.

[11] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-ca.pdf.

[12] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independ

This first-in-the-nation public-private partnership successfully lowered both the State's uninsured rate and hospitals' uncompensated care losses. *Arkansas Private Option 1115 Demonstration Waiver: 2014 Annual Report*, Ark. Dep't of Hum. Servs. 3 (2015).[13]

In 2016, Arkansas received further waiver authority with the Secretary's approval of the Arkansas Works demonstration project. Building on its 2013 demonstration project, Arkansas Works provided premium support for expansion beneficiaries on employer-sponsored insurance; required beneficiaries above poverty level to pay premiums; incentivized annual checkups with additional benefits; and, most relevant here, referred beneficiaries to the Arkansas Department of Workforce Services for job training and placement assistance. *See* Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Cindy Gillespie, Dir., Ark. Dep't of Hum. Servs. 1 (Dec. 8, 2016);[14] Arkansas 1115 Waiver Extension Application 10-14 (June 28, 2016).[15] The State expected that "as individuals receiving this referral bec[a]me employed . . . many [would] transition out of the Arkansas Works

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ence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf.

[13] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-annl-rpt-2014.pdf.

[14] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-amndmnt-appvl-12292017.pdf.

[15] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-application-07072016.pdf.

program to [employer-sponsored insurance] and private, individual market coverage." *Id.* at 14.

That 2016 project succeeded in further reducing the State's uninsured population, but the work-referral program was a disappointment. Though nearly a quarter of beneficiaries who acted on the referrals obtained employment, less than five percent of beneficiaries acted on the referrals. Dist. Ct. R. 39-2 at 2.

That experience led Arkansas to conclude that a stronger incentive model was necessary to achieve Arkansas's goals and make expansion workable in the long term. Therefore, in 2017, Arkansas proposed the Amendment at issue here. That amendment's centerpiece was a community-engagement requirement designed to "promot[e] personal responsibility and work," "encourag[e] movement up the economic ladder, and facilitate[e] transitions from Arkansas Works to employer-sponsored and [exchange] coverage." Pet.App. 192a. Under that requirement, non-exempt, able-bodied expansion beneficiaries under age 50 would be required to report 80 hours of work, work-related activities, education, or volunteering per month. Pet.App. 111a-115a.

To avoid coverage loss, Arkansas carefully designed its requirement to be attainable. Beneficiaries with minor dependents, students, pregnant women, the medically frail, those who experienced a life-changing event or family emergency, and many others were exempted. Pet.App. 112a-113a. Attendance at educational programs, including GED classes, counted towards the 80-hour requirement. Pet.App. 114a. So too did vocational training and up to 40 hours per month spent *looking* for work. *Id.* And the minimum wage was used as a proxy for work hours; thus, 40 hours of work at a wage twice the minimum would count as 80

hours. Pet.App. 113a n.2. Moreover, beneficiaries would only be deemed non-compliant if they failed to meet the requirement for three months. Pet.App. 117a. And non-compliant beneficiaries could reapply for benefits the next calendar year. Pet.App. 118a.

In March of 2018, after notice and comment, the Secretary, acting through the CMS Administrator, approved Arkansas's proposed amendment. Pet.App. 65a. In contrast to previous Section 1115 approvals, the Secretary issued a detailed letter responding to commenters' concerns and explaining why the amendment would likely promote the objectives of Medicaid. Pet.App. 66a-79a.[16]

The Secretary predicted that the community-engagement requirement would likely promote two Medicaid objectives. First, the Secretary explained that the agency had "an obligation to ensure that proposed demonstration programs are likely to . . . improve health and wellness." Pet.App. 69a. Citing studies finding that work and other forms of community engagement are correlated with improved health, the Secretary predicted the community-engagement requirement would promote beneficiary health by encouraging community engagement. Pet.App. 70a. Second, the Secretary found "it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means . . . to promote beneficiary independence." Pet.App. 75a; *see also* Pet.App. 67a (noting Arkansas's project "attempts to facilitate transitions between and among Arkansas Works, ESI, and the Marketplace for Arkansas Works enrollees").

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[16] For examples of Section 1115 approvals under the prior administration, *see* D.C. Cir. J.A., Vol. I, at 118-21, 127-29, 137-40, 147-48.

Responding to commenters' concerns that Arkansas's requirement would cause coverage loss rather than increase community engagement, the Secretary noted that Arkansas exempted beneficiaries who were unable to work; that his approval required the State to reach out to beneficiaries and explain how to comply and report compliance; and that beneficiaries would only lose coverage after failing to satisfy the requirement for three months. Pet.App. 73a-76a.

All things considered, the Secretary concluded that the requirement "create[d] appropriate incentives for beneficiaries to gain employment" and predicted that "the overall health benefits . . . through community engagement outweigh the health risks to those who fail to [comply] and who fail to seek exemption." Pet.App. 75a, 76a.

III. Procedural History

Several months after the Secretary approved Arkansas's demonstration project, the District Court for the District of Columbia held the Secretary's approval of Kentucky's similar demonstration project was arbitrary and capricious. *See Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018). There, Kentucky had predicted for budgetary purposes that under its project, its Medicaid expansion plan would cover 95,000 fewer people. *Id.* at 247. Though that figure reflected expected transitions to commercial and employer-sponsored coverage—not coverage loss—the district court attributed it entirely to the latter and faulted the Secretary for failing to address that supposed estimate. *See id.* at 262-64.

Emboldened by that decision, a group of Arkansas Works beneficiaries filed suit in the same district court. They claimed that the Arkansas Works Amend-

ment's approval was arbitrary and capricious under that court's reasoning in *Stewart*—though neither Arkansas nor any commenter had ever made a comparable estimate of a reduction in Medicaid expansion rolls. Pet.App. 31a, 35a. Arkansas intervened to defend its program. Pet.App. 32a.

As in *Stewart*, the district court concluded the Secretary's approval was arbitrary and capricious because the Secretary had said too little about coverage. Pet.App. 50a. In particular, the district court concluded that although the Secretary had "acknowledg[ed]" and addressed "at several points" comments predicting coverage loss, the Secretary had "fail[ed] to address whether coverage loss would occur." Pet.App. 40a. That supposed omission, the district court concluded, rendered his approval arbitrary and capricious. Pet.App. 50a.

The court of appeals affirmed, but on largely different grounds. It agreed with the defendants that under its precedent, when multiple statutory "objectives could point to conflicting courses of action," an "agency could give precedence to one or several objectives over others without acting in an arbitrary or capricious manner." Pet.App. 18a. Thus, the court of appeals suggested, if Medicaid had multiple purposes, one of which was beneficiary health, prioritizing beneficiaries' health over maximizing their ranks would have been permissible. Pet.App. 19a.

But the court of appeals declared that Medicaid was *not* a multi-purpose program. Pet.App. 16a. Instead, it held that Medicaid has just "one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage." *Id.* And it declared that "the alternative objectives of

better health outcomes and beneficiary independence are not consistent with Medicaid." *Id.*

The court of appeals rested its conclusion on the preamble to Medicaid's standing appropriations section. It acknowledged that "the Medicaid statute does not have a standalone purpose section like some social welfare statutes" in the Social Security Act. Pet.App. 10a. Yet it found what it deemed a statement of purpose in Medicaid's "appropriations provision" at Section 1901 of the Act. Pet.App. 10a-11a (citing 42 U.S.C. 1396-1). That section, enacted in 1965, states an *appropriations* purpose of providing "medical assistance on behalf of [needy] families with dependent children and of aged, blind, or disabled individuals"—that is, the original groups of Medicaid beneficiaries. Given that section, and Medicaid's definition of medical assistance as medical services or payment for them, Pet.App. 11a (citing 42 U.S.C. 1396d(a)), the court of appeals concluded the entire program's "primary objective" was "unambiguously" coverage. Pet.App. 12a (quoting *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984)).

Having concluded that a 56-year-old appropriations section was an exhaustive statement of Medicaid's purposes, the court of appeals held that health and independence were "non-statutory objectives." Pet.App. 19a. As to health, while the court of appeals acknowledged that health might well be Medicaid's "ultimate purpose[]," Section 1901 "makes no mention" of it. Pet.App. 13a. It therefore rejected any consideration of health on the grounds that the Secretary was bound by "the means [Congress] has deemed appropriate, and prescribed, for [its] pursuit"—that is, coverage—even though Section 1115 authorizes waiving Medicaid's substantive requirements to promote its objectives.

Id. (quoting *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994)).

As for financial independence, the court of appeals questioned whether the Secretary had relied on that objective, arguing it was absent from the "specific section" of the Secretary's approval addressing objectives and appeared only in responses to comments. Pet.App. 14a. Yet the court of appeals ultimately rejected financial independence on the grounds that it too was non-statutory—even though Section 1901 itself *says* a purpose of Medicaid appropriations was to "help [Medicaid's original beneficiaries] attain or retain capability for *independence* or self-care." Pet.App. 11a (quoting 42 U.S.C. 1396-1 (emphasis added)). The court of appeals concluded, however, that independence meant "functional independence," not "financial independence from government welfare programs." Pet.App. 15a.

Having determined the Secretary's approval pursued "an entirely different set of objectives than the one we hold is the principal objective of Medicaid," Pet.App. 18a, the court of appeals concluded that the approval was arbitrary and capricious.

Lastly, in contrast to the district court, the court of appeals did not claim that the Secretary said nothing about coverage loss. It acknowledged that the Secretary pointed to features of Arkansas's project that would mitigate coverage loss and predicted that the health benefits of the project would outweigh the risk of coverage loss. Pet.App. 17a-18a. But given its conclusion that coverage was the program's overriding objective, the court of appeals deemed these statements an inadequate, "conclusory" treatment of the problem. Pet.App. 18a.

Ultimately, however, the court of appeals' problem with the Secretary's approval was more fundamental: in predicting that the risks of coverage loss, no matter how slight, would be outweighed by the project's health benefits, the Secretary "prioritize[d] non-statutory objectives [over] the statutory purpose." Pet.App. 19a.

SUMMARY OF ARGUMENT

To decide this case, this Court need only affirm that health is at least *an* objective of Medicaid. The Secretary found that community engagement improves health, that Arkansas's demonstration project would likely incentivize that engagement, that engagement's health benefits would outweigh the risks of coverage loss, and that, as a result, Arkansas's demonstration project would likely promote Medicaid's objectives. But for the court of appeals' conclusion that coverage is Medicaid's sole, overriding objective, the conclusion would have readily survived review. Further, even if health weren't an object of Medicaid, reversal would still be warranted because the Secretary concluded that Arkansas's demonstration project would likely promote beneficiary independence and enhance core Medicaid coverage.

First, Medicaid isn't simply a promise to cover costs. To the contrary, Medicaid is a *health* care program, and its provisions are clearly intended to improve beneficiaries' health and well-being. Both the court of appeals and Respondents effectively concede as much by acknowledging that Medicaid's ultimate aim is protecting and improving beneficiary health.

Yet they argue the Secretary couldn't consider health in approving Arkansas's demonstration project because Medicaid pursues that aim through an extremely complex system of coverage and the Secretary is bound

by that approach. But that misapprehends Section 1115, which expressly empowers the Secretary to waive *any* of Medicaid's numerous and complex provisions if he believes that a demonstration project is likely to promote Medicaid's objectives. And the court of appeals' approach would call into question any number of existing waivers and curtail the Secretary's ability to approve future demonstration projects that aren't designed to simply to maximize benefits and enrollment.

No more persuasive is the suggestion that the preamble of Medicaid's 56-year-old appropriation section is an exhaustive statement of Medicaid's purposes. Rather, Medicaid's appropriations section is just that: an appropriations section. And even if that provision spoke to original Medicaid's objectives, it says nothing about the Medicaid expansion's purposes, and only that program that is at issue here. The Secretary's approval is not arbitrary and capricious.

Second, even applying Section 1901, the Secretary's approval was not arbitrary and capricious because that section provides that one purpose of Medicaid appropriations is helping beneficiaries achieve "independence or self-care"—an objective the Secretary relied on here. 42 U.S.C. 1396-1. The court of appeals and Respondents claim that, as used in Medicaid's appropriations section, "independence" merely means "functional independence"—that is, the ability to function in daily life without personal assistance. But that cannot be right because that would make independence synonymous with self-care and ignore a panoply of Medicaid eligibility provisions designed to transition beneficiaries from public assistance.

Third, even if coverage were Medicaid's sole objective, improving beneficiaries' health and helping them transition from public assistance serves that goal. For

the healthier beneficiaries are, and the more beneficiaries that transition to other coverage, the better Medicaid's chances of effectively and consistently covering the neediest populations.

The judgment below should be reversed.

ARGUMENT

I. Health is a Medicaid objective.

Improving and safeguarding beneficiaries' health is a Medicaid objective, and the Secretary's conclusion that Arkansas's demonstration project will likely promote that objective required the courts below to sustain his approval.

Section 1115 authorizes the Secretary to "waive compliance with any of the requirements of" Medicaid and approve a demonstration project "which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. 1315(a), (a)(1). As the court of appeals concluded, Medicaid "does not have a standalone purpose section like [other] welfare statutes." Pet.App. 10a. But that does not mean that Medicaid's purposes are unknowable. Rather, when a statute lacks a purpose section, this Court "look[s] to statutory text to determine purpose because 'the purpose of an enactment is embedded in its words.'" *Rowland v. Cal. Men's Colony, Unit II Men's Advisory Council*, 506 U.S. 194, 211 n.12 (1993) (quoting *United States v. Shirey*, 309 U.S. 255, 261 (1959)).

Here, the overriding objective of improving Medicaid beneficiaries' health is embedded throughout the statute. And despite rejecting the Secretary's conclusion that health is an objective, even the court of appeals was forced to concede that health might be Medicaid's

"ultimate purpose[]." Pet.App. 13a (internal quotation marks omitted). Thus, even on the court of appeals' logic, Medicaid is really about health and that court erred in holding the Secretary acted arbitrarily and capriciously in relying on health when he approved Arkansas's demonstration project.

A. Medicaid is about health.

As Justice Scalia once observed, to find a statute's purpose, "there is no substitute for the hard job . . . of reading the whole text." *Babbitt v. Sweet Home Chapter of Cmtys. for a Greater Oregon*, 515 U.S. 687, 726 (1995) (Scalia, J., dissenting). Indeed, to find a statute's "purpose the whole statute must be examined. Single sentences and single provisions are not to be selected and construed by themselves, but the whole must be taken together." *Pollard v. Bailey*, 87 U.S. 520, 525-26 (1874); *accord Dada v. Mukasey*, 554 U.S. 1, 16 (2008) ("In reading a statute we must not 'look merely to a particular clause,' but consider 'in connection with it the whole statute.'" (quoting *Kokoszka v. Belford,* 417 U.S. 642, 650 (1974)).

That job is especially hard here because Medicaid's text is "an aggravated assault on the English language, resistant to attempts to understand it." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 n.14 (1981). But despite Medicaid's complexity, the statute as a whole—and the ACA's amendments to it in particular—makes one thing abundantly clear: Medicaid is ultimately designed to improve beneficiary health. Its substantive focus on wellness, access, and quality underscores that point, as do other waiver provisions. And at an absolute minimum, those provisions establish that health is at least *an* objective of Medicaid that the Secretary could rely on in approving Arkansas's demonstration project.

1. Wellness. The Medicaid statute and the provisions governing the expansion population focus not simply on the costs of health care, as the courts below suggested, *e.g.*, Pet. App. 11a-12a, *Stewart*, 313 F. Supp. 3d at 267, but also on improving health outcomes and providing essential health services.

a. The ACA makes that focus clear at multiple points. For instance, in what might be the closest thing to a statement of the ACA's goals, it directs the Secretary to develop a "national strategy" encompassing both government and private coverage "to improve the delivery of health care services, patient health outcomes, and population health." 42 U.S.C. 280j(a)(1). That provision further requires the Secretary to identify "national priorities" for "improving the health outcomes . . . of health care." *Id.* 280j(a)(2)(A), (B)(i). And particularly relevant here, it instructs the Secretary to coordinate with States to implement those priorities in Medicaid. *Id.* 280j(a)(2)(D).

The ACA also gave similar instructions to the Medicaid and CHIP Payment and Access Commission (MACPAC). The MACPAC was created in 2009 to review Medicaid and CHIP policies and make reform recommendations. 42 U.S.C. 1396(b)(1). To fulfill that role, the ACA directed the MACPAC to, among other things, assess "the degree to which [Medicaid eligibility] policies provide health care coverage to needy populations." *Id.* 1396(b)(2)(B). But Congress did not stop there, as it would have if the lower courts' coverage-only understanding of Medicaid's purposes were correct. It also directed the MACPAC to review whether Medicaid coverage policies were helping beneficiaries "improve and maintain their health and functional status" and whether Medicaid quality-of-care policies "achieve their stated goals." *Id.*

1396(b)(2)(D)-(E). Thus, the lower courts' suggestion that improving beneficiary health isn't an objective of Medicaid—or, at a minimum, Medicaid expansion—conflicts with Congress's instructions to both the Secretary and the MACPAC.

b. The scope of benefits provided to expansion beneficiaries also uniquely underscores that beneficiary health is a function of Medicaid. Expansion beneficiaries do not receive the same benefits as original Medicaid beneficiaries. *See NFIB*, 567 U.S. at 584. Instead, Congress only granted them an "'essential health benefits' package." *Id.* at 576 (alteration omitted) (citing 42 U.S.C. 1396a(k)(1), 1396u-7(b)(5), 18022(b)). That benefits package is identical to the minimum benefit that the ACA required insurers to offer on the exchanges. 42 U.S.C. 300gg-6(a). And that package includes things like access to prescription drugs, "[p]reventive and wellness services," and pediatric dental care. *Id*. 18022(b)(1).

As that list and the phrase "essential health benefits package" reflect, in designing that package, Congress was most concerned with ensuring access to those services that are critical for long term health. Indeed, in instructing the Secretary on how he should determine what's essential, Congress directed the Secretary to "take into account the health care needs of . . . the population," *id.* 18022(a)(4)(D), assess whether enrollees "are facing any difficulty accessing *needed* services," *id.* 18022(a)(4)(G)(i) (emphasis added), and whether the benefits needed "to be updated to account for changes in medical evidence," *id.* 18022(a)(4)(G)(ii).

Moreover, at the same time, Congress also directed the Secretary to consider whether adding benefits would "increase costs" to the *program*—not simply whether it would decrease beneficiaries' medical expenses. *Id.*

18022(a)(4)(G)(iv). And that direction critically underscores that in enacting the ACA, Congress wasn't simply interested in filling a hole in the budgets of childless adults up to 133% of poverty through increased coverage, but in improving and promoting beneficiary health in a cost-effective fashion

c. In addition to the expansion's focus on improving health, many other features also underscore that Medicaid is about health. Consider, for instance, Medicaid's treatment of drug coverage. When Medicaid mandates that certain drugs be covered, it does not simply cover the most expensive drugs. Rather, it covers those with the greatest health benefits—like drugs that combat tobacco or opioid addiction—and excludes others. *See* 42 U.S.C. 1396r-8(d)(7)(A), (D); see also *id.* 1396r-8(d)(2)(A), (C), (H) (authorizing the exclusion of drugs used to gain weight, grow back hair, or treat erectile dysfunction), *id.* 1396r-8(d)(2)(A), (C), (H); *id.* 1396r-8(d)(4)(C) (authorizing exclusion of drugs that have no advantage over other covered drugs in terms of "effectiveness, or clinical outcome").

Equally illustrative is Congress's decision to give States the option, under the ACA, to include any A- or B-rated adult *preventive* service in its state plan and give States an incentive to do so through an increase in the federal government's share of Medicaid funding. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 4106, 124 Stat. 119, 559-60 (2010) (ACA) (codified at 42 U.S.C. 1396d(a)(13), (b)). Indeed, that provision, perhaps more than any other, reflects the ACA's philosophy that "an ounce of prevention truly is worth a pound of cure." H.R. Rep. No. 111-299, pt. 1, at 327 (2009).

Similarly, underscoring Congress's focus on promoting health, in 2009, Congress directed the Secretary to

conduct a childhood obesity demonstration project through Medicaid and CHIP that offered both parent and child education, counseling, and after-school exercise to "promote healthy eating behaviors and physical activity." *Id.* 1320b-9a(e)(3)(A)(ii).

Lastly, Medicaid's cost-sharing regime, too, exudes an ultimate purpose of beneficiary health by excluding those services that are the most essential to maintaining good health from cost-sharing and thereby incentivizing their use. So things like emergency services, *id.* 1396*o*(a)(2)(D), (b)(2)(D), 1396*o*-1(b)(3)(B)(vi), tobacco-cessation therapies for pregnant women, *id.* 1396*o*(a)(2)(B), (b)(2)(B), 1396*o*-1(b)(3)(B)(iii), and poignantly, COVID-19 testing are all exempt from cost sharing. *Id.* 1396*o*(a)(2)(F)-(G), (b)(2)(F)-(G), 1396*o*-1(b)(3)(B)(xi). But everything else, at least for expansion beneficiaries, may be subject to cost-sharing. *Id.* 1396*o*(a)(2)(A), (b)(2)(A), 1396*o*-1(b)(3)(A)-(B)(i) (exempting other populations, such as children).

2. Access. Medicaid's guaranteed access provisions similarly show that the program is ultimately designed to promote health. Indeed, Medicaid does not merely cover what care is available, but guarantees that beneficiaries actually receive prompt care. *See* 42 U.S.C. 1396a(a)(8) (requiring States to furnish "medical assistance . . . with reasonable promptness"). In fact, the ACA Congress amended the definition of "medical assistance"—the very term the court of appeals thought meant that Medicaid's overriding objective is coverage—to clarify that point. *See* ACA sec. 2304 (amending the definition to include "care and services themselves," not just payment for care); H.R. Rep. No. 111-299, pt. 1, at 649-50 (explaining the amendment's purpose).

Medicaid works to make that guarantee a reality in a number of ways. For instance, Congress designed

an elaborate "incentive" payment system that both rewards hospitals that serve a disproportionate share of Medicaid patients and "ensure[s] hospitals have the resources" to do so. *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1809 (2019); *see* 42 U.S.C. 1396r-4. Likewise, illustrating Medicaid's focus on health, Congress has mandated that State Medicaid plans *deliver* certain essential services, not just *cover* them. *See* 42 U.S.C. 1396(a)(62), 1396s(a)(2)(A) (child vaccinations); *see also id.* 1396d(r) (requiring States to set participation benchmarks for annual check-ups).

3. Quality. Medicaid also strives to ensure high quality services, and it uses health outcomes as the ultimate metric to determine quality. Indeed, throughout Medicaid, quality of care and health outcomes are practically synonyms. That too illustrates health is Medicaid's objective.

Approved State Medicaid plans, for example, must set forth "standards and methods that the State will use to assure that . . . care and services provided to [beneficiaries] are of high quality." *Id.* 1396a(a)(22). An approved plan's results are then measured using the Medicaid Quality Measurement program—an ACA addition to the statute. That program measures not just "the quality of health care furnished to Medicaid" beneficiaries, *id.* 1320b-9b(d)(1)(B), but, critically, Medicaid beneficiaries' ultimate "health quality" itself. *Id.* 1320b(d)(1)(A). And other requirements echo that overall approach. *Id.* 1396r(b)(2), (b)(4)(A)(i)-(ii) (requiring Medicaid-participant nursing homes to maintain services sufficient to "attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.").

Likewise, when Congress directed the Secretary, as part of the ACA, to test new cost-efficient payment and

delivery models, it instructed him to evaluate their effects on quality in terms of "patient-level outcomes." 42 U.S.C. 1315a(b)(3)(B), (b)(4)(A)(i). And when, also in the ACA, it gave States financial incentives to cover home care as an alternative to nursing homes, it required States to measure the services' quality, "linked" quality measurements to "outcome measures," and defined outcome measures in terms of "health stability, and prevention of loss in function." ACA sec. 10202(c)(6)(B), (c)(6)(C)(iii) (codified at 42 U.S.C. 1396d note).

4. Additional waiver provisions. In addition to Section 1115, several other Medicaid provisions empower the Secretary to grant waivers for projects that pursue specific objects that Congress deemed important. And unsurprisingly, a common theme of these waivers is the pursuit of health, tempered by considerations of cost.

Section 1115A is one particularly relevant example. Enacted in the ACA, Section 1115A created the Center for Medicare and Medicaid Innovation to test new models for payment and service delivery, 42 U.S.C. 1315a(a)(1), including ones contrary to existing law. *Id.* 1315a(d)(1) (authorizing waivers by the Secretary). Approved models must "address[] . . . deficits in care leading to poor clinical outcomes or potentially avoidable expenditures." *Id.* 1315a(b)(1). And uniquely illustrating Congress's interest in promoting health and reducing spending, after an initial trial period, the Secretary must modify or terminate an approved model unless he determines that: 1) the model improves patient-level outcomes without increasing spending; 2) reduces spending without affecting patient outcomes; or 3) improves quality and reduces spending. *Id.* 1315a(b)(3)(B), (b)(4)(A)(i).

* * *

Viewing Medicaid holistically, it cannot be gainsaid that health is that program's principal, overriding objective. The court of appeals erred in concluding otherwise. Indeed, even if health were not Medicaid's overarching objective, the provisions outlined above demonstrate it is at least *an* objective. The judgment below should be reversed.

B. Respondents' counterarguments lack merit.

Respondents concede that "improving health outcomes is clearly a . . . desired outcome" of Medicaid. BIO 29. They also seem to acknowledge that health is Medicaid's "ultimate purpose[]." *Id.* (quoting *MCI*, 512 U.S. at 231 n.4). Yet they claim the Secretary may only pursue that ultimate purpose through coverage and, therefore, insist the Secretary's only authority under Section 1115 is to maximize coverage. Indeed, echoing the court of appeals, they chide the Secretary for supposedly forgetting that "[a]gencies are 'bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.'" *Id.* (quoting *MCI*, 512 U.S. at 231 n.4). Those arguments lack merit.

1. Respondents are correct that agencies are bound by statutory means as well as ends. But it is Respondents' position that flouts that principle. When Congress enacted Medicaid to promote health, it chose the "means" of an enormously complex, detailed statute—not just a mandate to cover people. To the contrary, Medicaid coverage is defined by hundreds of pages of detailed provisions, and those details undisputedly bind the Secretary in his ordinary administration of the program.

This case, however, isn't about ordinary administration. It's about the Secretary's Section 1115 authority, and that section furthers the objectives of various Social Security Act programs, including Medicaid, through experimentation. Thus, the means at issue *here* is not Medicaid's complex coverage scheme, but the experimental waiver of "any of the requirements" of Medicaid that stand in the way of "promoting [its] objectives." 42 U.S.C. 1315(a)(1). It's that means that binds the Secretary here.

Yet Respondents insist that despite Section 1115's broad language—permitting the Secretary to waive any and all of Medicaid's requirements—he may only pursue the program's "ultimate purposes" through some boiled-down version of Medicaid's coverage requirements. The upshot of their position is that though the Secretary may waive coverage details, he may not waive requirements that go to who States must cover. But Section 1115 contains no such limitation, and Respondents' argument rewrites the statute to say something it does not. As the first court to interpret Section 1115 concluded in rejecting that precise atextual argument, "translat[ing] a selected number of [Medicaid's] requirements into objectives, so that those requirements cannot be waived under § 1115 does violence to the plain wording of [Section 1115]. There is no ascertainable basis for distinguishing the waivable 'requirement' from the unwaivable 'objective'." *Cal. Welfare Rts. Org.*, 348 F. Supp. at 496; *cf. Aguayo v. Richardson*, 473 F.2d 1090, 1104 (2d Cir. 1973) (Friendly, J.) (rejecting the contention that Section 1115 did "not permit the Secretary to waive any requirement of [the AFDC program] which might result in the curtailment or denial of assistance" because that statute "on its face . . . permits" waivers of any AFDC requirement).

2. Respondents' approach also wrongly assumes that coverage is Congress's only means of promoting health. Congress however has repeatedly utilized healthy-behavior incentives and inducements to promote health. And, at bottom, that's what a community-engagement requirement is.

For instance, in 2006, Congress required the Secretary to approve up to ten States' demonstration projects that "[p]rovid[ed] incentives to patients to seek preventive health care services," including enhanced health services for beneficiaries that used those services. 42 U.S.C. 1396u-8(a)(3), (a)(3)(B). After an initial five-year testing period, the Secretary was authorized to approve such programs in any State. *Id.* 1396u-8(a)(2)(A)(ii).

Similarly, in the ACA, Congress created the Medicaid Incentives for Prevention of Chronic Disease, which required the Secretary to approve demonstration projects that used cash awards to incentivize behaviors like quitting smoking or "[c]ontrolling or reducing [one's] weight." ACA sec. 4108(a)(3)(A)(ii) (codified at 42 U.S.C. 1396a note)).

Respondents' only answer to this history of congressionally authorized healthy-behavior incentives is that these provisions did not authorize *Section 1115* demonstration projects or reduce coverage. BIO 30. But the relevance of these provisions isn't that they directly authorized approving Arkansas's project. It's that they demonstrate that Congress has endorsed programs that pursue health through incentives and not just coverage. Respondents' demand for an identical match between the statute's non-1115 incentives and Arkansas's misses the entire point of Section 1115, which is to experimentally authorize things the rest of the statute does not.

II. Section 1901 is not a statement of the Medicaid expansion's objectives.

Despite all the textual evidence that health is a core Medicaid objective, the court of appeals held that it wasn't an objective because it could not find a reference to it in Medicaid's original authorization of appropriations section. Given Medicaid's complexity and lack of "a standalone purpose section," Pet.App. 10a, the court of appeals' "yearning for a textual anchor" is understandable. *Judulang v. Holder*, 565 U.S. 42, 61 (2011). But in miscasting Section 1901 as Medicaid's exhaustive statement of purpose, the court of appeals was forced to read language into it, read other language out, and misapprehend Section 1901's function.

A. Section 1901 says nothing about the Medicaid expansion's purposes.

The most fundamental defect in the court of appeals' holding is that Section 1901 plainly says nothing about the purpose of the Medicaid expansion.

Enacted in 1965, and last substantively amended in 1973,[17] Section 1901 says that Congress authorized Medicaid appropriations for the purpose of "furnish[ing] (1) medical assistance" to the four original Medicaid populations—needy "families with dependent children" and "aged, blind, or disabled individuals"—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.

That language might, at best, be read to vaguely allude to the objectives of Medicaid for its original

[17] That amendment expanded the provision's original reference to the "permanently and totally disabled" to include all "disabled." Pub. L. No. 93-233, sec. 13(a)(1), 87 Stat. 947, 960 (1973).

beneficiaries. But it obviously says nothing about the program's objectives for expansion beneficiaries: childless, non-disabled adults up to 133 percent of the poverty level. It does not state an objective of covering those beneficiaries, or any objectives concerning them at all. Indeed, if Section 1901 stated the program's sole purposes, as the court of appeals thought, then covering expansion beneficiaries at all would exceed Medicaid's purposes. Yet the expansion is law. So Section 1901 cannot be the exhaustive statement of purpose that the court of appeals thought it was.

The court of appeals did not address this problem. Instead, it simply applied the section's purposes to the Medicaid expansion as if expansion beneficiaries were mentioned there. But a court cannot alter "a provision's reach by inserting words Congress chose to omit." *Lomax v. Ortiz-Marquez*, 140 S. Ct. 1721, 1725 (2020). Nor can it "impos[e] limits on an agency's discretion that are not supported by the text." *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2381 (2020).

By contrast, the district court did address this problem. It suggested that Section 1901's silence on expansion beneficiaries was another ACA "example[] of inartful drafting," and simply read them into the section alongside their original-Medicaid counterparts. *Stewart*, 313 F. Supp. 3d at 269 (quoting *King v. Burwell*, 576 U.S. 473, 491 (2015)). And once read in, the district court concluded, that section would state the expansion's purposes.

Correcting drafting error, however, requires certainty "beyond question" that such error occurred. *U.S. Nat'l Bank of Ore. v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 462 (1993). The district court suggested that was the case here because, even before the ACA, Congress

had added other beneficiaries to Medicaid and had not added them to Section 1901. *Stewart*, 313 F. Supp. 3d at 270. "[Y]et," it concluded, "it is inconceivable that Congress intended to establish separate Medicaid programs, with differing purposes, for each" expansion. *Id.*

But the district court's focus on prior expansions misses the point. While it might be implausible that each of the incremental pre-ACA changes—adding groups like former foster youth, *id.*—had a different purpose, the ACA's expansion wasn't "a mere alteration of existing Medicaid." *NFIB*, 567 U.S. at 584. It launched "a new health care program" with an entirely different kind of beneficiaries entitled to a much narrower set of benefits than any previous group of beneficiaries. *Id*. (explaining that the expansion beneficiaries are eligible solely because of their income). So it's hardly inconceivable that Congress had different purposes in mind when it created such a vastly different, new program more than half a century after original Medicaid. *Id*.

That conclusion, moreover, is reinforced by other changes to Medicaid over the last half century and in the ACA itself. For instance, as explained in greater detail above, both in the ACA and in other amendments proceeding it, Congress repeatedly enacted provisions designed to incentivize healthy behavior and tailor coverage to improve beneficiaries' health outcomes. And the Medicaid expansion came on the heels of previous changes to eligibility requirements—totally absent in 1965—designed to encourage social welfare beneficiaries to work, gain financial independence, and take more responsibility for their own well-being. *Infra* at 40-41.

Thus, even if the court of appeals were correct about Medicaid's original purposes, it is hardly inconceivable

that those purposes have changed over the last half century. It certainly isn't inconceivable that they changed when Congress adopted a new health care program. If anything, it would be inconceivable to think they hadn't. The court of appeals' contrary conclusion is erroneous.

B. In any event, Section 1901 is not an exhaustive statement of Medicaid's purposes.

The court of appeals' reading of Section 1901 poses a paradox. If Section 1901 states Medicaid's purposes, why hasn't Congress updated it to reflect changes to the program? Indeed, as the district court noted, that provision isn't just silent as to expansion beneficiaries; it also says nothing about other beneficiaries that have been added since 1965. The answer to that paradox is that Section 1901's role is far more modest: It merely gave future Congresses the requisite parliamentary authorization to appropriate Medicaid funds. Its statement of purpose therefore merely described—but did not limit—the general objects of Medicaid spending as it existed at the time.

1. Section 1901 does not look like any purpose section this Court has ever interpreted. Entitled "Appropriations," it says that "For the purpose" of providing medical assistance to the original Medicaid beneficiaries and services to help them attain capability for independence or self-care, "there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter." 42 U.S.C. 1396-1.

This is not how purpose sections typically read. Purpose sections—including social welfare programs' purpose sections—are typically entitled "Purpose" and

begin "The purpose of this [program/part/chapter] is." *See, e.g.*, 42 U.S.C. 601(a) (TANF's "Purpose" section) ("The purpose of this part is"); 42 U.S.C. 1397aa(a) (SCHIP's "Purpose" section) ("The purpose of this subchapter is"). Section 1901 looks nothing like that. It says that for two enumerated purposes, funds are authorized in a sum sufficient to carry out the unnamed "purposes of this subchapter."

2. That remarkably different phraseology is no accident. Instead, it reflects Section 1901's far more limited role of authorizing Congress to appropriate Medicaid funds.

When Congress appropriates funds for a program, "typically" it "passes an Act authorizing appropriations" before appropriating funding for it. *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1319 (2020) (citing U.S. Gov't Accountability Office, GAO-16-464SP, *Principles of Federal Appropriations Law* 2-56 (4th ed. 2016) (GAO Redbook)). That has been Congress's practice in Medicaid, where it annually appropriates the spending Section 1901 authorizes, *see* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, div. A, tit. II, 133 Stat. 2534, 2568 (2019), and in a host of other social-welfare programs. *See, e.g.*, 7 U.S.C. 2027(a)(1) ("authoriz[ing] to be appropriated such sums as are necessary" for SNAP); 42 U.S.C. 1381 ("authoriz[ing] to be appropriated sums" for Supplemental Security Income Congress later appropriates).

"Congress can deviate from this pattern," *Me. Cmty. Health Options*, 140 S. Ct. at 1319, however, because rather than being legally required, authorizations are parliamentary formalities. That is, they are enacted to comply with House rules that require appropriations to have been authorized by non-appropriations law. *See* GAO Redbook 2-55; *TVA v. Hill*, 437 U.S. 153, 190-

91 (1978). Failing to enact one "subject[s] the 'offending' appropriation to a point of order," but once enacted—and many are, *see* GAO Redbook 2-80 n.72—an unauthorized appropriation has every bit as much legal effect as an authorized one. *Id.* 2-55.

Accordingly, authorizations do no truly legal work. Rather than speak to the executive branch, an authorization like Section 1901 is only "a directive to *Congress itself*" that "serves little purpose other than to comply with [the] House Rule" requiring pre-appropriation authorization. *Id.* 2-56 (emphasis added). Congress directs agencies on how to spend appropriated funds through programs' organic statutes, or appropriations provisions themselves—not through authorizations—and it did so in Medicaid. *See* 42 U.S.C. 1396b(a) (directing the Secretary to fund States' Medicaid plans); Further Consolidated Appropriations Act, 2020, div. A, tit. II (same).

That limited function also explains why Congress has never seen fit to update Section 1901. Because it doesn't tell the Secretary what purposes to pursue or even how to spend Medicaid funds, Section 1901's silence on beneficiary changes since 1965 poses no difficulty. The Secretary simply follows the Medicaid statute.

3. Besides Section 1901's function, its text also indicates that its preamble was not intended to be an exhaustive statement of Medicaid's purposes. That's because Section 1901 does not only authorize appropriations for the purposes listed in its preamble. Rather, in language the court of appeals didn't cite, it "authorized to be appropriated for each fiscal year a sum sufficient to carry out *the purposes of this subchapter*." 42 U.S.C. 1396-1 (emphasis added).

If the purposes stated in the section's preamble were the Medicaid subchapter's *only* purposes, as the court of appeals suggested, Congress wouldn't have referred more broadly to "the purposes of this subchapter," indicating there were others. It would have simply said "those purposes" to refer back to the ones stated.

That it didn't also makes perfect sense. Had Congress only authorized appropriations to carry out the purposes it listed in 1965, appropriations for new Medicaid beneficiaries and objectives to come might have been technically unauthorized, necessitating perpetual amendments. By expressly acknowledging "purposes of this subchapter" beyond the ones it listed, Congress wrote an authorization that could last—and that has lasted since its enactment, even as Medicaid has been transformed. Thus, Section 1901 itself tells us not to read the purposes in its preamble as the sole purposes of Medicaid. And as explained above, health is plainly one of Medicaid's objectives.

III. The court of appeals' coverage-only reading of Medicaid's appropriations section is erroneous.

Even if Medicaid's more than half-century old appropriation section stated Medicaid's objectives, the court of appeals erred in concluding that Medicaid has "one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage." Pet.App. 16a. That error led it to erroneously hold that any Section 1115 Medicaid demonstration project must "promote the objective of providing coverage." Pet.App. 13a.

That approach is untenable because, among other things, Congress has rejected it, it ignores Section 1901's

focus on independence, it neglects the relationship between coverage and sustainability, and it would invalidate a whole host of other Section 1115 demonstration projects.

A. Congress has rejected the court of appeals' coverage-only reading of Medicaid's objectives.

Since 1965, Congress has adopted a series of Medicaid amendments that underscore coverage is not Medicaid's sole objective. Those amendments establish that the Secretary may approve programs that do things other than increase coverage—and even limit coverage.

Most tellingly of all, aware that the Secretary had approved coverage-reducing waivers in the past,[18] Congress amended Section 1115 in the ACA to *say* that the Secretary may approve Medicaid demonstration projects that "would result in an *impact* on eligibility, enrollment, benefits, cost-sharing, or financing." 42 U.S.C. 1315(d)(1) (emphasis added). Indeed, far from barring the Secretary from approving waivers that could reduce enrollment, limit benefits, or reallocate coverage, that amendment merely required the Secretary to adopt notice-and-comment procedures for such projects. *Id.*

That amendment's language, moreover, stands in stark contrast to other ACA provisions that bar the Secretary from approving coverage-reducing waivers outside Medicaid. *See id.* 18052(b)(1)(A)-(B) (authoriz-

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[18] *See* S. Rep. No. 111-89 at 97 (2009) (discussing the Bush Administration waivers that expanded coverage to ineligible populations, subject to the Office of Management and Budget's requirement of budget neutrality that required corresponding coverage cuts).

ing the Secretary to waive the individual mandate and other central provisions of the ACA—but only if those waivers "provide coverage that is at least as comprehensive . . . [and] affordable as the provisions of this title would provide"). And that contrast underscores that Congress did not intend to prohibit Section 1115 waivers that reduce coverage.

Even if Congress had enacted a less germane amendment to Section 1115—as it has fourteen times before and since the ACA[19]—its silence in the face of coverage-reducing waivers would strongly suggest that practice was consistent with the statute. For when Congress revisits a "statute without pertinent change . . . congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress." *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 275 (1974). But "[w]here as here, 'Congress has not just kept its silence by refusing to overturn the administrative construction, but has ratified it with positive legislation,' [courts] cannot but deem that construction virtually conclusive." *Commodity Futures Trading Comm'n v. Schor*, 478 U.S. 833, 846 (1986) (quoting *Red Lion Broad. Co., Inc. v. FCC*, 395 U.S. 367, 381-82 (1969)).

Schor is a particularly apt comparison to Congress's ratification of coverage-reducing waivers in Section 1115. In *Schor*, after the CFTC adopted a disputed practice of hearing state-law counterclaims, Congress generally authorized the CFTC to promulgate rules on the scope of its counterclaim jurisdiction. That, the

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[19] *See, e.g.*, Consolidated Appropriations Act, 2001, Pub. L. No. 106-554, sec. 703, 114 Stat. 2763, 2763A-754 (2000) (codified at 42 U.S.C. 1315(f)) (enacting procedures for extending Section 1115 waivers); Balanced Budget Act of 1997, Pub. L. No. 105-33, sec. 4757, 111 Stat. 251, 527 (1997) (same) (codified at 42 U.S.C. 1315(e)).

Court held, ratified the CFTC's state-law counterclaim practice. *See id.* Here, Congress was even more direct. It not only authorized the Secretary to issue rules about how he approved waivers, but specifically authorized rules regarding *coverage-reducing* waivers—the type of waiver whose permissibility is in controversy here.

Further, the ACA's amendment to Section 1115 is not the only time Congress has authorized coverage-reducing Section 1115 waivers. In 1982, after a decade of Section 1115 waivers that authorized then-forbidden cost-sharing, Congress circumscribed, but did not eliminate, the Secretary's authority to grant such waivers. Instead, it adopted a provision allowing the Secretary to grant them if he found they would "provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients." 42 U.S.C. 1396*o*(f)(3).

Yet on the court of appeals' theory, such cost-sharing would have *no benefits* that the Secretary could consider in granting a waiver. Its benefits, like reducing cost, deterring wasteful care, and helping beneficiaries prepare to buy commercial coverage are what the court of appeals called "non-statutory objectives" that the Secretary may not consider. Pet.App. 19a. And its costs simply amount to a reduction of what the court of appeals deemed Medicaid's overriding purpose, paying for care. That interpretation of the statute cannot be correct, because the statute itself contradicts it.

B. Under Section 1901, independence is a Medicaid objective.

To the extent that Section 1901 states Medicaid's objectives, it makes beneficiary independence an objective. The Secretary was therefore entitled to rely on his conclusion that helping beneficiaries become

financially independent would likely promote Medicaid's objectives. Yet the court of appeals concluded that financial independence was not an objective of the Medicaid program. That conclusion is wrong and conflicts with multiple Medicaid provisions that pursue that objective.

1. Section 1901 *says* beneficiary independence is a Medicaid objective. It says Medicaid appropriations were authorized "[f]or the purpose" of furnishing "services to help [Medicaid's original beneficiaries] attain or retain capability for independence or self-care." 42 U.S.C. 1396-1. And no one disputes that community-engagement requirements help beneficiaries gain new skills, find gainful employment, and ultimately become financially independent. Pet.App.70. Thus, applying Section 1901, the Secretary could conclude that Arkansas's demonstration project was likely to promote independence and approve Arkansas's project on that basis.

The court of appeals erroneously rejected that approach. Read in "context," the court of appeals argued, independence meant "achieving functional independence," or put differently, the ability to live without nursing or home health care. Pet.App. 15a.

But that context demonstrates the opposite. Section 1901 says that funds are authorized to be appropriated to help beneficiaries attain "independence *or self-care*," 42 U.S.C. 1396-1 (emphasis added), and the court of appeals' reading makes the former a synonym of the latter. That both creates surplusage and ignores Congress's use of the disjunctive "or," which indicates the two terms have different meanings.

Moreover, the court of appeals' interpretation is difficult to square with Section 1901's statement that

appropriations are authorized to provide services to needy "families with dependent children . . . to help such families"—rather than just the elderly or disabled—"attain or retain capability for independence." *Id.* Indeed, it is not at all clear how such families could attain *functional* independence, but it is easy to understand how they could attain financial independence.

2. Other provisions confirm that Medicaid is concerned with more than just functional independence, and that Congress was concerned with helping beneficiaries attain financial independence.

For starters, Medicaid authorizes States to offer "prevocational, educational, and supported employment services" that help disabled beneficiaries find jobs. *Id.* 1396n(c)(5)(B) (waiver authority), (i)(1) (plan amendment authority). Those services—like those set forth in Arkansas's approval—include job placement, training, and coaching. And decades after Congress created the Medicaid authority for those services, Congress gave States financial incentives to provide them in the ACA and required States to measure their effects on "achieving desired outcomes . . . including employment [and] participation in community life." ACA sec. 10202(c)(6)(C)(iii) (codified at 42 U.S.C. 1396d note).

Congress has also repeatedly tied Medicaid eligibility to work for the stated purpose of encouraging beneficiaries to work and become financially independent. In 1988, for example, Congress provided temporary Medicaid eligibility to families whose earnings would otherwise make them ineligible. 42 U.S.C. 1396r-6. That amendment was explicitly designed "to help families off the welfare rolls and into jobs" by removing the "disincentive for many mothers

to seek and accept employment" that their children's Medicaid ineligibility would otherwise pose. S. Rep. No. 100-377, at 10-11 (1988).

Additionally, in 1996 Congress gave States the option to terminate TANF recipients' Medicaid coverage if they refused to meet TANF's work requirement. 42 U.S.C. 1396u-1(b)(3)(A). Both Respondents and the court of appeals dismiss this provision as a mere "coordination" of Medicaid and TANF eligibility. BIO 31 n.11; Pet.App. 15a. But nothing required Congress to coordinate the two, and the provision is no small matter since virtually all TANF recipients receive Medicaid assistance. *Characteristics of Families Receiving Multiple Public Benefits*, Urban Inst. 1 (February 2014).[20]

More recently, in the Ticket to Work and Work Incentives Improvement Act of 1999, Congress gave States the option to provide Medicaid coverage to working disabled individuals whose earnings would otherwise make them ineligible. 42 U.S.C. 1396a(a)(10)(a)(ii)(XV)-(XVI). And underscoring Congress's desire to help even traditional beneficiaries attain financial independence, that provision was specifically designed to "enable such individuals to maintain employment" and "reduce their dependency on cash benefit programs." Pub. L. No. 106-170, sec. 2(b), 113 Stat. 1860, 1863 (1999).

It therefore cannot be gainsaid that financial independence is an objective of Medicaid and the Secretary did not act arbitrarily and capriciously in approving Arkansas's demonstration project.

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[20] https://www.urban.org/sites/default/files/publication/22366/413044-Characteristics-of-Families-Receiving-Multiple-Public-Benefits.PDF.

C. Improving beneficiary health and encouraging financial independence promote coverage.

Even if coverage were Medicaid's sole objective, the Secretary could still rely on health and independence because those things promote coverage.

The healthier Medicaid beneficiaries are, and the more Medicaid beneficiaries graduate to private coverage, the more resources States have available to cover their least healthy and neediest beneficiaries' care. Indeed, this Court has previously concluded that keeping borderline populations off Medicaid serves the program's objectives because it frees up resources to cover the neediest. And consistent with that conclusion, Medicaid is filled with provisions designed to contain costs and conserve resources. Thus, even on the court of appeals' untenably minimalist account of Medicaid's objectives, the aims the Secretary pursued were permissible.

1. Running Medicaid is expensive. Today, Medicaid accounts for nearly 29 percent of total State spending, and federal funding only pays for 63 percent of it. *2020 State Expenditure Report*, Nat'l Ass'n of State Budget Officers 52 (2020).[21] And though state spending on Medicaid is immense, it is not limitless. To the contrary, as the Secretary has explained, most Medicaid spending goes towards optional benefits and populations—including the expansion population at issue here—and "[e]very Medicaid dollar a State saves is a dollar that it can spend providing coverage for additional individuals or providing additional benefits." Gov't Pet. 23; *cf. Aguayo v. Richardson*,

[21] https://www.nasbo.org/mainsite/reports-data/state-expenditure-report.

473 F.2d 1090, 1103-04 (2d Cir. 1973) (Friendly, J.) (observing, in upholding a State's experimental welfare work requirement under Section 1115, that "common sense would lead to th[e] conclusion" that "extension of assistance to cases where [beneficiaries are] capable of earning money would diminish the funds available for cases where they were not").

The Medicaid statute reflects this idea. For instance, underscoring Congress's desire to preserve scarce resources, the Secretary is specifically authorized to grant waivers designed to "promote cost-effectiveness and efficiency" and "reduce program costs." 42 U.S.C. 1396n(b), 1315a(b)(2)(A). He likewise has broad authority to implement initiatives designed to improve Medicaid's "efficiency," including "incentives to promote greater use of generic drugs" instead of branded ones. *Id.* 1396b(z)(1), (2)(E). And more broadly, the Medicaid statute requires every state Medicaid plan to contain "safeguard[s] against unnecessary utilization" of Medicaid services, and provisions that ensure Medicaid "payments are consistent with efficiency [and] economy." 42 U.S.C. 1396a(a)(30)(A); *see id.* 1396r-8(g)(1)(A) (State drug plans must include provisions designed to reduce "excessive utilization" and "medically unnecessary care"); *id.* 1396b(i)(4) (no payment can be made to a hospital unless it has a review committee that evaluates the services it provides for medical necessity and efficiency, including the duration of hospital stays).

Moreover, this Court has squarely held that controlling Medicaid costs—through programs designed to keep borderline populations healthy and off Medicaid—serves Medicaid objectives. In *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003), drug manufacturers claimed Medicaid preempted a state law that required prior authorization for

Medicaid purchases from manufacturers who declined to provide discounts for non-Medicaid purchases. A three-Justice plurality upheld the law on the grounds that prior authorization served the "rather obvious Medicaid purpose," *id.* at 663, of "[a]voiding unnecessary costs in the administration of a State's Medicaid program." *Id.* at 664. And it held the non-Mediciad discounts also served Medicaid purposes, by both lowering the cost of drugs for "borderline" non-Medicaid patients and preventing them from falling ill and "end[ing] up in the Medicaid program" and heading off even more expensive treatment if they did fall into the program. *Id.* at 663-64.

Justice Breyer concurred on the ground that the law might further the "Medicaid-related objectives" the plurality identified. *Id.* at 671 (Breyer, J., concurring in part and concurring in the judgment). Justice Thomas, relying on some of the provisions mentioned above, concurred on the ground that Medicaid pursues "interests such as cost control" just as much as it pursues the purpose of care. *Id.* at 676 (Thomas, J., concurring in the judgment). And critically, in reaching that conclusion, Justice Thomas also rejected the court of appeals' suggestion that Medicaid has just one sole purpose, explaining that "[t]he text of this complex statute belies" any real "effort[] to distill from it a single purpose." *Id.*

The upshot of *Walsh* for this case is simple: if cutting Medicaid costs and preventing people from ending up on Medicaid serve Medicaid objectives, so does lowering costs by making beneficiaries healthier and helping them out of Medicaid.

2. Applying those principles here, the Secretary properly concluded that reducing Medicaid costs through health and independence enhances Medicaid

coverage. Community-engagement requirements, as the Secretary explained, do this in two critical ways. First, working or volunteering is strongly correlated with improved health and the surest way to reduce cost is by improving the health of those it covers. Second, requirements like those at issue here encourage those who can do so to earn their way out of eligibility and into the exchanges or employer-sponsored coverage. That frees up resources to serve—as Medicaid was designed to do—the neediest.

3. Respondents' only real retort to the connection between health, independence, and sustainability is a slippery-slope argument: if the Secretary may stretch Medicaid coverage by reducing costs, then the Secretary can simply slash eligibility and reduce benefits. BIO 33. But that doesn't follow. Rather, consistent with the sustainability theory endorsed in *Walsh*, the Secretary would still be limited to approving waivers that he believes will help beneficiaries to transition to non-Medicaid coverage or that improve their health.

The Secretary predicted Arkansas's project would do exactly that, reducing cost (not coverage) and enhancing the coverage of those who remain on the program. That conclusion is well grounded in both statutory text and case law, and Respondents cannot show that conclusion is arbitrary and capricious.

D. The court of appeals' approach would radically alter the Secretary's Section 1115 authority.

Under the court of appeals' approach, the Secretary could only approve projects that are likely to maximize coverage. That approach would foreclose not just community-engagement projects, but any experimental program that might impact the scope of benefits, and

limit a valuable tool for testing innovative approaches to social welfare policy. That would radically alter the scope of the Secretary's discretion and call into question a host of existing waivers.

In particular, the court of appeals' rule would preclude the Secretary from approving projects that test healthy-behavior incentives. Those programs generally seek to incentivize healthy behavior through increased benefits, cash rewards, or lower cost-sharing. Michigan, for example, requires beneficiaries above 100 percent of poverty level to obtain a health risk assessment or engage in other healthy behaviors, such as getting vaccinations. Such programs undoubtedly promote health (and make Medicaid sustainable), but it is not at all clear how those programs could survive the court of appeals' coverage-maximization test. And underscoring the point, the same plaintiffs who have challenged Michigan's community-engagement requirement have also challenged Michigan's healthy-behavior-incentive project. See *Young v. Azar*, No. 1:19-cv-3526, D. Ct. Doc. 1, at 23-24, 47-48 (D.D.C. Nov. 22, 2019).

But the impact of such a narrow reading of Section 1115 would not just be limited to healthy-behavior incentives. At a much more fundamental level, such a narrow reading threatens to severely curtail the kind of experimentation that has proven so valuable in setting national health care policy.

For example, a vast number of Section 1115 Medicaid waivers permit States to test covering services outside the statute's definition of medical assistance, or even an ordinary understanding of the term. Those experiments test whether new services are worth covering, and how state Medicaid programs can best deliver them. If the Secretary has the power to promote

health, those waivers are entirely unproblematic. But if the Secretary's charge under Section 1115 is simply to directly promote furnishing "medical assistance," as the court of appeals believed, the Secretary may not authorize waivers for services the statute says are *not* medical assistance. *See, e.g.*, 42 U.S.C. 1396d(a)(30)(A) (providing "such term does not include" services in institutions for mental disease); *Medicaid Waiver Tracker*, *supra* (enumerating waivers in 31 States to cover substance abuse treatment in institutions for mental disease). Thus, the court of appeals' rule, though superficially maximizing coverage, would spell the end of experimentally covering new Medicaid services.

Nor would the court of appeals' rule permit the Secretary to experiment with covering new beneficiaries. Section 1115 expansion waivers tested the policies on which the Medicaid expansion was built, and they continue in various forms to the present day—sometimes in response to local health emergencies,[22] sometimes to test covering new groups of beneficiaries.[23] If Medicaid is about promoting the health of the neediest among us, the long history of expansion waivers makes sense. But if Medicaid's sole purpose is directly furnishing medical assistance to statutory beneficiaries, the Secretary has been acting outside

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[22] *See* Letter from Andrea J. Casart, Dir., Div. of Medicaid Expansion Demonstrations, Ctrs. for Medicare & Medicaid Servs., to Chris Priest, Dir., Mich. Med. Servs. Admin. (Aug. 8, 2017), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-health-impacts-potential-lead-exposure-ca.pdf (granting waiver to cover victims of Flint, Michigan, lead-contamination exposure).

[23] *See Expanding Postpartum Medicaid Coverage*, Kaiser Fam. Found. nn. 8-9 & accompanying text (Dec. 21, 2020), available at https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

his authority for decades. For even assuming, as the courts below suggested, that later beneficiaries can be read into Section 1901, no one has ever suggested that provision states a purpose of providing coverage to those who are statutorily *ineligible*. Here too, then, the court of appeals' rule, though ostensibly maximizing coverage, would bar experiments (like the Massachusetts program that the expansion was modeled on) that expand it.

In sum, by narrowing Medicaid's Section 1115 "objectives" to the provision of existing Medicaid services to existing Medicaid beneficiaries, the court of appeals' reading would leave hardly any room for experimentation at all. All the Secretary could approve is waivers that provide for more of what Medicaid provides already. That isn't the authority to "test out new ideas" and policies Congress intended, S. Rep. No. 87-1589, at 19; it's a strait-jacket. The court of appeals' interpretation cannot be correct, and this Court should reverse it.

IV. The Secretary's approval was not arbitrary and capricious.

Because health and independence are Medicaid objectives, the Secretary's approval was not arbitrary and capricious. The Secretary predicted that the Arkansas Works Amendment would likely promote beneficiary health and independence. Neither the district court nor court of appeals found that prediction unreasonable. Under the court of appeals' approach below, that means the Secretary's approval was lawful. For under that approach, where a statute has "several possible objectives," it is "enough for the agency to assess at least one." Pet.App. 18a (citing *Fresno Mobile Radio, Inc. v. FCC*, 165 F.3d 965, 971 (D.C. Cir. 1999) (Ginsburg, J.) ("When an agency must balance a number

of potentially conflicting objectives . . . judicial review is limited to determining whether the agency's decision reasonably advances at least one of those objectives and its decisionmaking process was regular.")).

That approach to arbitrary-and-capricious review under a multi-objective statute is the correct one. As Judge Wald explained in one of the early decisions adopting it, "only the [agency] may decide how much precedence particular policies will be granted when several are implicated in a single decision." *MobileTel, Inc. v. FCC*, 107 F.3d 888, 895 (D.C. Cir. 1997). A court cannot decide how much weight the Secretary should give coverage relative to health. That would "substitute [its policy judgment] for that of the Secretary." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2569 (2019). Indeed, this Court held in *Department of Commerce* that where an agency's choice "call[s] for value-laden . . . weighing of incommesurables"—there, whether "the value of obtaining more complete and accurate citizenship data . . . was worth the risk of a potentially lower response rate"—that choice is the agency's to make. *Id.* at 2571. Similarly, here the Secretary concluded that the health benefits of enhanced community engagement outweighed the risks of coverage loss. Pet.App. 76a-77a. How to weigh those incommensurables was likewise his prerogative.

Further, even if the Secretary were required to consider potential coverage losses beyond choosing to place greater weight in his decision on health benefits, the Secretary did consider coverage. As the court of appeals acknowledged, the Secretary responded to comments raising coverage, pointed to multiple features of Arkansas's project that would mitigate coverage loss, indicated he believed that the community-engagement requirement would "adequately incentivize beneficiary

participation" as to avoid substantial coverage loss, Pet.App. 75a, and ultimately concluded that the likely health benefits of the project outweighed the risks of coverage loss.

What the court of appeals really faulted the Secretary for, then, was failing to estimate the amount of coverage loss. But while "[i]t is one thing to set aside agency action under the Administrative Procedure Act because of failure to adduce empirical data that can readily be obtained," "[i]t is something else to insist upon obtaining the unobtainable." *FCC v. Fox Television Stations*, 556 U.S. 502, 519 (2009). The Secretary could not predict the precise outcome of Arkansas's experiment, turning on the vagaries of human behavior as it did, without conducting the experiment first. As Judge Friendly wrote of Section 1115 approvals, "it is legitimate for an administrator to set a lower threshold for persuasion when he is asked to approve a program that is avowedly experimental and has a fixed termination date." *Aguayo*, 473 F.2d at 1103.

Again, *Department of Commerce* is helpful. There, the Secretary of Commerce, advised by his own Census Bureau that a citizenship question would depress response rates, concluded that given the "limited empirical evidence" to that effect, he could not "determine definitively" whether the Bureau was right. 139 S. Ct. at 2563. He then concluded that the value of citizenship data outweighed the uncertain risks of lower response. *Id.* This Court did not require more; it found his "uncertainty" "justifiabl[e]," and his ultimate weighing reasonable. *Id.* at 2571. The Secretary's consideration of coverage here was no different. Faced with comments predicting coverage loss on the basis of surmise or the history of other programs, the Secretary found the potential for cover-

age loss uncertain and concluded that the benefits of approval outweighed the uncertain risks. The APA required no more.

CONCLUSION

This Court should reverse the court of appeals' judgment.

Respectfully submitted,

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APPENDIX

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TITLE 42—THE PUBLIC HEALTH AND WELFARE

§ 1315. Demonstration projects

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In 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 subchapter I, X, XIV, XVI, or XIX, or part A or D of subchapter IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and

(B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV and which are not included as part of the costs of projects under section 1310 of

this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such subchapters for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such subchapters and is not included as part of the cost of projects for purposes of section 1310 of this title.

(b) Child support enforcement programs

(1) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of subchapter IV, the project—

(A) must be designed to improve the financial well-being of children or otherwise improve the operation of the child support program;

(B) may not permit modifications in the child support program which would have the effect of disadvantaging children in need of support; and

(C) must not result in increased cost to the Federal Government under part A of such subchapter.

(2) An Indian tribe or tribal organization operating a program under section 655(f) of this title shall be considered a State for purposes of authority to conduct an experimental, pilot, or demonstration project under subsection (a) to assist in promoting the objectives of part D of subchapter IV and receiving payments under the second sentence of that subsection. The Secretary

may waive compliance with any requirements of section 655(f) of this title or regulations promulgated under that section to the extent and for the period the Secretary finds necessary for an Indian tribe or tribal organization to carry out such project. Costs of the project which would not otherwise be included as expenditures of a program operating under section 655(f) of this title and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under a tribal plan or plans approved under such section, or for the administration of such tribal plan or plans, as may be appropriate. An Indian tribe or tribal organization applying for or receiving start-up program development funding pursuant to section 309.16 of title 45, Code of Federal Regulations, shall not be considered to be an Indian tribe or tribal organization operating a program under section 655(f) of this title for purposes of this paragraph.

(c) Demonstration projects to test alternative definitions of unemployment

(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of subchapter IV in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 607 of this title. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test

and evaluate the total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the 100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 607 of this title.

(2) Notwithstanding section 602(a)(1) of this title, a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 602(a)(3) of this title. Such agreement shall provide for the payment of aid under the applicable State plan under part A of subchapter IV as though section 607 of this title had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of section 607 of this title (and, except as provided in paragraph (2), any related requirements and conditions under part A of subchapter IV).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control groups comprised of a random sample of individuals receiving aid under section 607 of this title and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

(d) Regulations relating to applications for or renewals of demonstration projects

(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of subchapter XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under subchapter XIX or XXI (in this subsection referred to as a "demonstration project") shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after March 23, 2010, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(B) requirements relating to—

(i) the goals of the program to be implemented or renewed under the demonstration project;

(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with subchapter XIX or XXI;

(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

(E) a process for the periodic evaluation by the Secretary of the demonstration project.

(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

(e) Extensions of State-wide comprehensive demonstration projects for which waivers granted

(1) The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of subchapter XIX is granted under subsection (a).

(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect

to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title), of the project.

(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the

Secretary's best estimate of rates of change in expenditures at the time of the extension.

(f) Application for extension of waiver project; submission; approval

An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection referred to as the "waiver project") shall be submitted and approved or disapproved in accordance with the following:

(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to review the terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed

to by the chief executive officer of the State), the Secretary shall—

(i) approve the application subject to such modifications in the terms and conditions—

(I) as have been agreed to by the Secretary and the State; or

(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the overall objectives of the waiver project, and not in violation of applicable law; or

(ii) disapprove the application.

(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title).

(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).

§ 1396–1. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance 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, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.