Nos. 20-37 & 20-38

IN THE

Supreme Court of the United States

NORRIS COCHRAN, ACTING SECRETARY OF HEALTH & 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 *AMICI CURIAE* FOR PUBLIC HEALTH, HEALTH POLICY AND MEDICINE DEANS, CHAIRS AND SCHOLARS IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Table of Contents

Table of Contents

Page

TABLE OF CITED AUTHORITIES

Page

CASES

Cited Authorities

FEDERAL STATUTES

Page

FEDERAL REGULATIONS

LEGISLATIVE MATERIALS

Page

OTHER SOURCES

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

Page

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

Centers for Medicare and Medicaid Services ..... CMS

Medicaid and CHIP Payment and Access Commission..... MACPAC

Patient Protection and Affordable Care Act ..... ACA

Social Security Act .....SSA

State Medicaid Directors Letter.....SMDL

U.S. Department of Health and Human Services.. HHS

U.S. Government Accountability Office ..... GAO

INTEREST OF *AMICI CURIAE*

The Deans, Chairs, and Scholars are researchers and academics who are experts in the fields of health law, public health and health care policy and research, and national health reform. They seek to inform this Court about the history of Section 1115 of the Social Security Act, 42 U.S.C. § 1315, and the essential elements of Medicaid demonstration evaluation. Federal Petitioners' use of demonstration authority to allow States to impose work or community engagement requirements on Medicaid beneficiaries is inconsistent with the Medicaid program, the Social Security Act, Section 1115 authority and its purpose, Congressional intent, and the historical use of such demonstration authority, rendering Petitioners' actions contrary to federal law.[1]

The full list of *amici curiae* Deans, Chairs and Scholars is printed in an appendix to this brief.

1. Pursuant to Supreme Court Rule 37.6, *amici* certify that no party or counsel for a party authored this brief in whole or in part, and no party other than *amici* or their counsel contributed money intended to fund the preparation or submission of the brief. The parties have consented to the filing of this brief.

INTRODUCTION

Congress enacted the Medicaid program, Title XIX of the Social Security Act ("SSA"), to provide medical assistance to people whose income and resources are insufficient to pay the cost of necessary care. 42 U.S.C. § 1396–1. Despite this clear mandate, the U.S. Department of Health and Human Services' ("HHS") Centers for Medicare and Medicaid Services ("CMS") (collectively "Petitioners") allowed Arkansas and New Hampshire to make "community engagement" through compelled work a condition for Medicaid eligibility. In doing so, Petitioners relied on special experimental authority conferred on the HHS Secretary under § 1115 of the Social Security Act. These consolidated matters now before this Court challenge the Court of Appeals' well–reasoned ruling that authorization of the demonstrations at issue was arbitrary and capricious, and therefore unlawful. CMS has notified the States of Arkansas and New Hampshire that "…allowing work and other community engagement requirements to take effect in New Hampshire [and Arkansas] would not promote the objectives of the Medicaid program." *See* Letter from Elizabeth Richter, CMS Acting Administrator to Lori Shibinette, Commissioner, New Hampshire Department of Health and Human Services (Feb. 12, 2021); Letter from Elizabeth Richter, CMS Acting Administrator to Dawn Stehle, Arkansas Medicaid Director (Feb. 12, 2021).[2] This Court should affirm.

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2. Reportedly, the Arkansas Department of Human Services "will not request a continuation of its controversial 'work requirements' policy…." David Ramsey, *Arkansas DHS wants Work Incentive for Medicaid Expansion Plan*, Magnolia Reporter.Com (Feb. 20, 2021).

The Arkansas and New Hampshire demonstrations reduce Medicaid coverage and create barriers to eligibility. For example, Arkansas launched its demonstration in June 2018 and by March 2019, when the District Court halted it, over 18,000 Arkansans had lost coverage, despite the fact that over ninety–six percent of those targeted by the policy appeared either to meet the work requirements or qualify for an exemption. Independent analysis documented that the uninsured rate for the initial work requirements group (ages 30–49) increased seven percent and Medicaid coverage decreased by seven percent compared to working age beneficiaries not included in the initial experimental wave. *See* Benjamin D. Sommers *et al.*, *Medicaid Work Requirements – Results from the First Year in Arkansas*, The New Eng. J. Med. (June 19, 2019); Benjamin Hardy, *Study says Medicaid Work Requirement Increased Uninsured Rate for Arkansas but did not boost Employment,* Arkansas Times (June 19, 2019). Further, independent analysis found that the Arkansas demonstration did not lead to a significant change in employment a year thereafter. *See* Benjamin D. Sommers *et al.*, *Medicaid Work Requirements in Arkansas: Two–Year Impacts on Coverage, Employment, and Affordability of Care*, Health Affairs (Sept. 2020).

Section 1902 of the SSA sets forth detailed conditions of State participation in Medicaid. *See* 42 U.S.C. § 1396a. Longstanding decisions hold that while States have options to expand eligibility and coverage, they cannot impose eligibility or coverage restrictions not authorized by law. *See T.H. v. Jones*, 425 F.Supp. 873, 877 (D. Utah 1975), *aff'd sub nom. Jones v. T.H.*, 425 U.S. 986 (1976) (invalidating Utah's parental consent requirements for Medicaid family planning services); *Comacho v. Tex.*

Workforce Comm'n, 408 F.3d 229, 235 (5th Cir. 2005) ("Texas cannot add additional requirements for Medicaid eligibility."); Edward C. Liu & Jennifer A. Staman, Cong. Research Serv., R44802, Judicial Review of Medicaid Work Requirements Under Section 1115 Demonstrations (Mar. 28, 2017) at 3 n.17.

Section 1115 of the SSA authorizes the Secretary to modify certain State plan requirements under § 1902 "[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…[Medicaid]." 42 U.S.C. § 1315(a)(1). Medicaid's core statutory objective is provision of medical assistance to eligible persons. 42 U.S.C. § 1396–1. Yet Petitioners abused this unique experimental authority and approved the Arkansas and New Hampshire demonstrations by ignoring the fundamental research norms on which § 1115 rests. Contrary to basic research principles, petitioners disregarded voluminous evidence – much of it flowing from the government's own research – regarding the impact of compelled work experiments on the health and well–being of public benefit recipients. *See* E. Brantley *et al.*, *As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful*, Health Affairs (Feb. 17, 2021). Petitioners ignored the critical flaws in their experimental design along with a wealth of research pointing to major, negative impact on enrollment and coverage. Through administrative fiat, and without statutory authority or notice–and–comment rulemaking, Petitioners reversed their long–standing position that work requirements do not promote the objectives of the Medicaid program – an ideological position made abundantly clear nearly a year prior to approval of the

initial experiments that demonstrated the depth of the administration's hostility to insurance coverage for poor adults. *See* U.S. Dept. of Health & Human Servs., *"Dear Governor" letter from Thomas E. Price, Secretary of HHS & Seema Verma, CMS Administrator* (Mar. 14, 2017) (hereinafter, "Dear Governor Letter"). Ark. App. 195–198 (Exh. 97); N.H. App. 68–70 (Exh. 3).[3]

Petitioners disregarded the research and evaluation principles that undergird § 1115. Arkansas implemented its "demonstration," and months of erroneous coverage termination ensued with no evaluation in place. *See* Letter from Andrea J. Cassart, CMS Division of Medicaid Expansion Demonstrations to Dawn Stehle, Arkansas Medicaid Director (Nov. 8, 2018) (asking Arkansas, in the midst of implementation, to revise the unapproved evaluation design "on areas that should be better articulated or strengthened"). Thousands of beneficiaries were put directly in harm's way without the safeguards of a sound experiment – a hypothesis based in evidence, a reasonable research design, and careful, timely evaluation to ensure that impact can be measured and, most importantly, that the experiment can be halted before it threatens health and well–being.

Section 1115 is not a mechanism for refashioning Medicaid in ways that federal officials might prefer but that lack statutory basis. This law is a unique grant of power from Congress to test, measure, and evaluate the

3. "Ark. App." refers to the appendix in *Gresham v. Azar*, 363 F.Supp.3d 165 (D.D.C. 2019), *available at*: 1:18-cv-01900-JEB (Mar. 6, 2019) (Doc. 53 *and attachments*). "N.H. App." refers to the appendix in *Philbrick v. Azar*, 397 F.Supp.3d 11 (D.D.C. 2019), *available at*: 1:19-cv-00773-JEB (July 3, 2019) (Doc. 41 *and attachments*).

impact of policy modifications that have the potential to promote Medicaid objectives. As discussed below, Petitioners' use of § 1115 is contrary to the terms, purpose, and history of this special federal experimental authority. Hence, Petitioners' approval of these demonstrations was arbitrary, capricious, and contrary to law. Consequently, *amici* urge this Court to affirm.

SUMMARY OF THE ARGUMENT

I. In 1962, the Kennedy Administration asked Congress to pass legislation allowing States to implement demonstration projects without having to comply with all requirements of the Social Security Act. In enacting that legislation, Congress envisioned demonstrations of limited scope and geographic impact that would serve as narrow, beneficial research options.

II. Early demonstrations adhered to Congress's intent. In implementing § 1115, the Department of Health, Education, and Welfare clarified that its purpose was to improve the administration of assistance and related services designed to help needy persons achieve self–support, self–care, or to maintain and strengthen family life. After Congress authorized the Medicaid program in 1965 and subsequently extended demonstration authority to Medicaid, Department guidance continued to affirm that demonstration projects should focus on program improvement.

III. Following Medicaid's enactment, Congress took additional steps to ensure § 1115 experiments adhere to research norms and promote program purpose. For over 45 years, Medicaid demonstrations have assessed new

approaches to deliver health care or expand beneficiary services and supports. Throughout, HHS has consistently viewed Medicaid eligibility as a benefit to be distinct from programs whose express purpose is to promote work.

IV. Contrary to § 1115's terms and purpose, Petitioners used demonstration projects to circumvent the Affordable Care Act's expansion of Medicaid. Since the early Trump administration, Petitioners embraced a plan to reverse the expansion population's Medicaid eligibility, which they characterized as "a clear departure from the core, historical mission of the [Medicaid] program." In approving the Arkansas and New Hampshire demonstrations, Petitioners offered no explanation of how eliminating insurance furthers financial sustainability, ignored evidence of past failures and widespread adverse impact, and failed to consider the consequences of driving up uninsured rates on States' budgets as Medicaid coverage declined under the weight of the experiment.

V. The demonstrations at issue are unlawful because Petitioners have grossly exceeded the experimental authority set forth in § 1115. Petitioners acted contrary to sound research principles and instead pursued a policy of "experiment first and evaluate later," ignored voluminous comments in the record that warned of the demonstrations' likely impact and allowed the Arkansas experiment to proceed without an independent, rigorous evaluation. Furthermore, at least in Arkansas, the lack of an evidence–based experimental design led to confusion, unreliable research findings, and hardship to Medicaid beneficiaries.

VI. Section 1115 contemplates that States file experimental applications accompanied by costs and

coverage projections, and that States and Petitioners meet other requirements to ensure transparency. The GAO deemed CMS inconsistent in its compliance with transparency and other § 1115 requirements. CMS' § 1115 guidance contradicted Petitioners' approval of Arkansas's demonstration, which was allowed to proceed without an evaluation design, beneficiary surveys or other essential research safeguards.

VII.A. Petitioners' improper use of § 1115 jeopardized the substantial healthcare coverage and access gains of Medicaid expansion. Given well–documented similar effects following implementation of work requirements in SNAP and other social programs, Petitioners were thoroughly apprised of the substantial negative impacts that would result from approving these demonstrations.

VII.B. Experiments to reduce Medicaid coverage contradict voluminous research demonstrating the adverse effects of denying low–income people access to health insurance. The record contains extensive opposition to CMS' "community engagement" policy as an eligibility condition, based on multiple evaluations showing the disastrous impact of work requirements in TANF and other social programs. CMS was also warned repeatedly regarding extensive research on the adverse impact of coverage lock–outs such as those contemplated by Arkansas's demonstration. Furthermore, federal officials disregarded ample research on the extent to which most adult Medicaid beneficiaries already work or are limited in their ability to do so.

VII.C. Petitioners justified their approval of these demonstrations by claiming, without explanation, that work requirements create "appropriate" incentives for

beneficiaries to gain employment or help individuals and families attain or retain capability for independence or self–care. To the contrary, there is no evidence suggesting that depriving people of Medicaid will create greater levels of employer–sponsored insurance.

ARGUMENT

I. Congress Enacted § 1115 to Permit States to Test New Approaches to Expand Access, Provide Better Services, and Strengthen Social Programs.

In 1962, the Kennedy Administration asked Congress to enact legislation authorizing "[d]emonstration projects that states could undertake without having to meet all the conditions of the federal [Social Security] act." Public Welfare Amendments of 1962, Pub. L. 87–543, § 122, 76 Stat. 172, 192 (1962); *see also* S. Rep. No. 1589, at 1 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1947. The President identified "needed improvements" in safety net programs including liberalization of eligibility requirements and benefit rules. *See* Social Security Administration, Social Security History: Kennedy's Statements on Social Security (Feb. 20, 1961). This additional authority would help, not penalize, the poor: "[c]ommunities which have – for whatever motives – attempted to save money through ruthless and arbitrary cutbacks in their welfare rolls have found their efforts to little avail. The root problems remained…." *President's Special Message to the Congress on Public Welfare Programs* (Feb. 1, 1962).

Explaining that demonstration authority would enable states "to improve the techniques of administering assistance and the related rehabilitative service under the

assistance titles," the Senate envisioned demonstrations of limited scope and limited geographic impact, and disfavored duplication of demonstration projects. S. Rep. No. 1589, *supra*, at 1943, 1961. Furthermore, "[a]t the committee hearing, no witness suggested – nor did the Finance Committee ever intimate – that section 1115 was to be used to reduce benefits by varying eligibility criteria….In short…Congress and the Administration intended this section to be a narrow, technical, and beneficent research option." Lucy A. Williams, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 Yale L. & Pol'y Rev. 1, 12, 13 (1994).

II. Early § 1115 Demonstrations Heeded Congressional Intent that Experiments Strengthen Medicaid and other Social Programs.

In implementing § 1115, the agency clarified that its purpose was to "develop and improve the methods and techniques of administering assistance and related services designed to help needy persons achieve self–support or self–care or to maintain and strengthen family life." U.S. Dep't of Health, Educ. & Welfare, Handbook of Public Assistance Administration, H.T. No. 4, pt. IV, § 8421 (1963). Early on, demonstrations were intended to augment and strengthen services, not eliminate them. Williams, *The Abuse of Section 1115 Waivers* at 14.

Congress authorized the Medicaid program with enactment of Title XIX of the Social Security Act in 1965, 42 U.S.C. § 1396 *et seq*., and extended demonstration authority to Medicaid. *See* Social Security Amendments of 1965, Pub. L. No. 89–97, sec. 121(c)(3), § 1115, 79 Stat. 352 (42 U.S.C. § 1315 (Supp. I 1965)). Subsequent 1967

Department policy reaffirmed that demonstrations ought to strengthen programs by "provid[ing] assistance to needy individuals *who would not otherwise be eligible*; increas[ing] the level of payments; provid[ing] social services not presently available…; [and] experiment[ing] with new patterns and types of medical care…." U.S. DEP'T OF HEALTH, EDUC. & WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, H.T. No. 109, pt. IV, § 8432 (Feb. 17, 1967) (emphasis added) (*cited* in Williams, *supra*, at 14, n.29); *see also* S. Rep. No. 744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 2863 (appropriating additional funds for § 1115 projects "to develop demonstrations in improved methods of providing service to recipients or in improved methods of administration").

III. Since 1965 Congress Has Added Important Protections to Ensure Demonstrations Promote Medicaid's Purpose.

Over decades, Medicaid demonstrations have tested new strategies for delivering health care or expand beneficiary services. Congress has taken additional steps to ensure § 1115 experiments promote Medicaid's purpose. In 1982, Congress added § 1916 to the SSA to restrict § 1115 waivers that compel beneficiary participation in premium or cost-sharing demonstrations. Tax Equity and Fiscal Responsibility Act, Pub. L. 97–248, Title I, Subtitle B, § 131(b), 96 Stat. 367 (1982); 42 U.S.C. § 1396o. Congress again amended § 1115 in 2010 to require that, prior to approving demonstrations, the Secretary provide public notice and comment at both the state and federal levels and ensure that demonstrations comply with federal Medicaid law. *See* Patient Protection and Affordable Care Act, Pub. L. 111–148, § 2601(b)(2), § 10201(i), 124 Stat. 119, 922 (2010) (the "ACA"); 42 U.S.C. § 1315(d)(2).

No previous Administration has approved Medicaid demonstrations whose express purpose is to deprive people of eligibility or coverage, and CMS has historically rejected such proposals. Indeed, over the past quarter century, the Secretary has permitted experiments aimed broadly at broadening eligibility, testing alternative approaches to eligibility expansion, improving coverage, and introducing health care innovations. Alexander Somodevilla *et al.*, *How Far Do Section 1115 Medicaid Experiments Designed to Restrict Eligibility and Enrollment Veer From the Norm? A 25-Year Perspective*, Geo. Wash. Health Pol'y & Mgm't Matters (June 13, 2019). The text and history of § 1115 show that this experimental authority is not a blank check to rewrite law by stripping eligibility from beneficiaries; it is unlikely "that Congress would enact such comprehensive [Social Security Act] regulations, frame them in mandatory language, require the Secretary to enforce them, and then enact a statute [§ 1115] allowing states to evade these requirements with little or no federal agency review." *Beno v. Shalala*, 30 F.3d 1057, 1068–69 (9th Cir, 1994); *see also Newton–Nations v. Betlach,* 660 F.3d 370 (9th Cir. 2011).

The history of welfare reform legislation reveals that HHS has consistently viewed Medicaid eligibility as a benefit to be "decoupled" from programs whose express purpose is to promote work, such as Temporary Assistance for Needy Families ("TANF"), which statutorily ties benefits to work activities. *See* Letter from Olivia Golden, Assist. Secretary for Children and Families & Nancy–Ann Min DeParle, Administrator, Health Care Financing Administration to State Medicaid Directors and TANF Administrators (June 5, 1998). Historically, CMS has repeatedly opposed work requirements. *See Medicaid*

at 50: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Health, 114th Cong. 7 (July 8, 2015) (responses to additional questions for the record of Vikki Wachino, CMS Deputy Administrator and Director for the Center for Medicaid and CHIP Services) ("the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work or receive job training because that is not an objective of [Medicaid]"); *see also* Letter from Vikki Wachino to Jeffrey A. Meyers, Commissioner, New Hampshire Dept. of HHS (Nov. 1, 2016) (denying State's request for permission to implement Medicaid work requirements because they "undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program"); Letter from Andrew M. Slavitt, CMS Acting Administrator to Thomas Betlach, Director, Arizona Health Care Cost Containment System (Sept. 30, 2016); Sidney D. Watson, *Out of the Blackbox and into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213, 227 (Winter 2015) ("The Secretary has no Section 1115 authority to allow a work requirement or work incentive.").

As noted, CMS has now returned to its consistently held view. *See* Letters from Elizabeth Richter, CMS Acting Administrator to Arkansas and New Hampshire (Feb. 12, 2021), respectively, *supra*. Petitioners' now disavowed change of heart that underlay these demonstrations deserves little deference: "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view.'" *INS v. Cardoza–Fonseca*, 480 U.S. 421, 446 n.30 (1987).

IV. Petitioners Cannot Use § 1115 as a Shortcut for Reversing Expansion.

As Petitioners acknowledge, the two experiments at issue in these matters concern the "Medicaid expansion," which secured medical assistance for previously ineligible low–income, working–age adults. Federal Pet'rs' Br. at 15, 31. The ACA extended medical assistance to "the entire nonelderly population with income below 133 percent of the poverty level." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012); *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (extending Medicaid coverage effective Jan. 1, 2014 to the "expansion population"). States may choose not to cover the ACA expansion population. *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 587. However, States that decide to provide coverage must afford the expansion group "full benefits," which the statute defines as "medical assistance…that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for [other] individual[s] [covered under the Act]." 42 U.S.C. § 1396d(y)(2)(B). The federal government covers ninety percent of a State's costs of providing medical assistance to the expansion group. *Id.* § (y)(1)(D), (E).

Early in the Trump administration, Petitioners embraced a plan to roll back the expansion population's Medicaid eligibility, characterized as "a clear departure from the core, historical mission of the [Medicaid] program." *See* Dear Governor Letter at 1. N.H. App. 68. CMS advanced its views in a January 2018 State Medicaid Directors Letter (the "SMDL") inviting submission of "community engagement" demonstration

proposals containing a host of eligibility restrictions. *See* Ark. App. 74–83; N.H. App. 57–66. Upending its long–standing position that mandatory work requirements do not promote Medicaid objectives, CMS made a policy about–face without notice–and–comment. The letter also promoted other coverage restrictions such as premiums, "lock–out" periods that could bar coverage for months at a time, and elimination of retroactive eligibility. The policy expressly established an experimental design consisting of a year–round, hours–per–week work requirement despite evidence that fewer than one in six working–age low income adults can satisfy this standard. Low–wage workers, particularly those in retail, hospitality, or transportation, are vulnerable to job insecurity and precarious work schedules – a reality especially common among low–wage workers who also depend on government safety net programs. *See* Michael Karpman *et al.*, *Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements* 1–2, URBAN INSTITUTE (June 11, 2019). Petitioners' policy also sanctioned volunteer work without wages or benefits and barred use of Medicaid experimental funds to underwrite work supports such as training, transportation, or child care. Petitioners encouraged this model even though voluntary work programs have shown no measurable success in boosting work, *see* Leighton Ku *et al.*, *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?*, THE COMMONWEALTH FUND (Nov. 6, 2018), and in the case of New Hampshire, with no regard to the State's extremely low average unemployment rates (2.6 percent), even among older adults (1.8 percent). *See* U.S. DEPT. OF LABOR, Bureau of Labor Statistics, *Databases, Tables & Calculators by Subject* (Table: 2018 Unemployment New Hampshire

Data). Regardless, Petitioners remained silent as to how unemployed beneficiaries should meet the 100–hour monthly requirement or if there were any jobs available in a virtually full–employment local economy.

Moreover, Petitioners offered no explanation of how eliminating coverage for an eligibility group whose costs qualify for a ninety percent federal contribution rate (42 U.S.C. §§ 1396d(y)(1)(D), (E))), while pushing up uninsured rates, advances the goal of financial sustainability. Nor did Petitioners weigh the consequences for New Hampshire of such a loss of federal match, estimated at between $114 million and $174 million in 2020 alone, an impact of up to eleven percent of the State's budget. Sherry A. Glied, *How a Medicaid Work Requirement Could Affect New Hampshire's Economy*, The Commonwealth Fund (May 9, 2019).

V. Petitioners' Approvals of Eligibility Restriction Experiments in Arkansas and New Hampshire Violated Research Norms by Lacking A Basis in Evidence and by Failing to Ensure States Conduct Adequate Demonstration Evaluations.

Petitioners offered varying justifications for compelled work experiments. Initially, they asserted, work would improve health. Before this Court, they argue that compelled work will promote access to private insurance, in direct contravention of the fact that the two major avenues to private insurance – Marketplace coverage and employer plans – are closed to the working poor because they lack sufficient income to qualify for Marketplace subsidies and work in jobs that overwhelmingly offer no employer health benefits. *See* Sara Rosenbaum *et al.*, *The*

Trump Administration's Deeply Flawed Assumptions that Underlie its Medicaid Compelled Work Experiments, Geo. Wash. Health Pol'y & Mgm't Matters (Feb. 8, 2021). Moreover, Petitioners' exemption procedures, which could have given a modicum of beneficiary protection against the experiment's harsh consequences, were so convoluted that less than forty percent of all surveyed Arkansas physicians in one study indicated they would assist the most severely affected people seek exemption from work requirements. *See* Harald Schmidt *et al.*, *Physicians and Medicaid Work Requirements: Variability in Primary Care Physician Response to Patient Exemption Requests*, SSRN (Feb. 12, 2021).

Contrary to all sound research norms, Petitioners allowed Arkansas to proceed without a rigorous evaluation in place, pursuing a policy of "experiment first and evaluate later" that made a mockery of § 1115's experimental authority and ignored the voluminous comments in the record that warned of the design's likely impact. Petitioners permitted an experiment carrying substantial risks for low–income adults, such as inflexible work rules or forced volunteer work carrying virtually no prospects of additional income or benefits, and exceedingly confusing reporting obligations. Over 18,000 people lost coverage in Arkansas with no government–funded research to assess the impact. These substantive and procedural flaws left the agency, States, and Congress without objective evidence of the consequences of the design on beneficiaries or what drove coverage loss – precisely the result lawmakers sought to avoid through the 2010 amendments.

Furthermore, the record is devoid of evidence showing the methodological soundness of the experiment. *See, e.g.*, *Newton–Nations*, 660 F.3d 370 (Medicaid) and *Beno*, 30 F.3d 1057 (Aid to Families with Dependent Children). Neither the original solicitation nor the approvals explained why it is methodologically sound to design work experiments that contradict the lessons of past compelled work demonstrations. Even as CMS refused to fund work supports, it also disregarded evidence of the harms that could befall low–wage or volunteer workers unable to navigate a new maze of experimental requirements. *See* Ku *et al.*, *Medicaid Work Requirements*, *supra*; Brantley *et al.*, *As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful*, *supra.*

In addition, § 1115 demonstrations must rest on research norms to ensure that experimental projects produce valuable information and facilitate "true research data[,] and serve interests beyond state fiscal concerns." *Recent Case: Ninth Circuit Holds Statutory Waivers for Welfare Experiments Subject to Judicial Review,* 108 Harv. L. Rev. 1208, 1212 (1995). "[T]he Secretary must make at least some inquiry into the merits of the experiment—she must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration." *Beno*, 30 F.3d at 1069. Moreover, "[t]he Secretary's second obligation under *Beno* is to 'consider the impact of the state's project on the persons the Medicaid Act 'was enacted to protect.'" *Newton–Nations*, 660 F.3d at 381. At least in the case of Arkansas, failure to produce a sound experimental design led inevitably to confusion, contamination of research findings, and additional hardship to more than 18,000 beneficiaries who lost Medicaid coverage.

Regulations issued in 2012 require that demonstrations serve a legitimate experimental purpose. 42 C.F.R. Part 431, subpart G. These regulations require States to submit for CMS approval detailed evaluation designs of their demonstrations' "key programmatic features," including testable hypotheses, valid designs, reliable collection methods and approaches to minimize burdens on beneficiaries. *Id.* at § 431.424; *see also* U.S. Gov't Accountability Office ("GAO"), GAO–19–315, Medicaid Demonstrations: Approvals of Major Changes Need Increased Transparency at 23, n.28 *and accompanying text* (Apr. 2019) (hereinafter "Medicaid Demonstrations – 2019 Report") ("In the development of demonstration evaluations, states are to include hypotheses that will be tested through the demonstrations, which align with the demonstration's objectives or goals."). Rather than adhering to their own standards for ensuring reasonable experimentation, Petitioners authorized States to proceed without an approved evaluation design. Arkansas's ran for ten months, with no approved, operational evaluation in place.

Petitioners would shield these deeply flawed demonstrations behind an insurmountable wall of deference to the "agency's predictive judgment." *See* Federal Pet'rs' Br. at 26. Petitioners justify approving work requirements on the ground that "[t]he purpose of such experiments is…to test a hypothesis. And an experiment can further the statute's goals whether or not it yields the results the agency anticipates–either by validating a hypothesis that might lead to new innovations, or by refuting a hypothesis, helping Congress and HHS avoid mistaken policies." *Id.* at 26; *see also* Ark. App. 6, N.H. App. 11, 12.

But in the context of experimental authority, predictive judgment is bound by fundamental research principles. Petitioners misused and exceeded their authority by ignoring the fundamental research tenet that the assumptions underlying a hypothesis be reasonable and that benefits outweigh risks. Their hypotheses were swamped by a massive body of evidence documenting the enormous likelihood of harm and they allowed a dangerous experimental design to proceed in an evaluation–free zone. Quality research rests on hypotheses based in evidence, reasonable experimental design, and evaluation of impact. Of course, Petitioners do not alert this Court to the fact that the Arkansas demonstration proceeded without an evaluation in place.

Petitioners also note that "[d]emonstration projects are time–limited experiments, and even an unsuccessful experiment can provide useful information that can 'influence policy making at the State and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other States.'" Federal Pet'rs' Br. at 26. However, making an experiment time–limited is not license to ignore the requirements of a reasonable hypothesis and experimental design demonstrating benefits that outweigh risks, and a sound evaluation that ensures experimentation will stop in the face of evidence of harm. No set of principles could be more fundamental in an experiment that involves depriving the poor of their essential means of health care. Time limits were of no use in an evaluation–free experiment that caused such enormous and immediate harm. *See* U.S. Gov't Accountability Office, GAO–18–220, Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies

AND PROCEDURES (Feb. 20, 2018) (citing Petitioners' poor record of § 1115 research oversight and failure to produce evaluation results). Petitioners ignored their responsibility to assess whether these demonstrations are "likely to assist in promoting the objectives" of Medicaid, an express statutory duty clearly not among those unreviewable, limited "categories of administrative decisions that courts traditionally have regarded as committed to agency discretion." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2568 (2019).

VI. Petitioners Consistently Sidestepped Evaluation Principles Contained in Their Own § 1115 Guidance.

Section 1115 contemplates that States file experimental applications accompanied by costs and coverage projections. 42 U.S.C. § 1315(d)(2)(B)(ii). It is not enough for States simply to report on the ongoing results of their demonstrations, although reporting is a requirement. *Id.* § 1315(d)(2)(D). Moreover, the statute provides that "[t]he Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final [state] report." *Id.* § 1315(e)(5). In other words, § 1115 demonstrations must be objectively evaluated for their impact, in contrast with routine Medicaid program administration. This obligation to assess coverage impact and to evaluate results applies to new demonstrations and to extensions or renewals as in Arkansas and New Hampshire, though Petitioners did not comply with it.

Applications to extend existing demonstrations, such as Arkansas's and New Hampshire's, must include "[a]n evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and

if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions." 42 C.F.R. § 431.412(c)(2)(vi). The GAO evaluated CMS' compliance with this regulatory provision and noted that CMS improperly deemed Arkansas's application to be "complete" despite lacking a revised evaluation design plan and specifically, that Arkansas had offered two new hypotheses that did not address "the waiver for retroactive eligibility proposed in the application." GAO, Medicaid Demonstrations – 2019 Report at 23, n.29 *and accompanying text*. Arkansas was allowed to simply submit a slapdash amendment to its original demonstration and Petitioners approved it in spite of it lacking impact estimates, new hypotheses or an evaluation design to test the added features. *See* Ark. App. 45–52 (XIV. EVALUATION OF THE DEMONSTRATION) (referencing only premium assistance; no hypotheses or evaluation design to test work requirements or coverage lock–out impacts).

More than a year after the initial § 1115 work approvals and about nine months after the Arkansas demonstration went live, CMS posted § 1115 online resources on State evaluation and monitoring obligations. *See* CMS, Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations (hereinafter "CMS 1115 Guidance") *and* CMS, Appendix to Evaluation Design Guidance for 1115 Eligibility and Coverage Demonstrations: Community Engagement. N.H. App. 58–91 (Exh. 56 and 57).

CMS' guidance "…encourage[d] states to procure their evaluator to support the development of a robust

draft evaluation design for CMS review; ideally, states should identify an evaluation team before implementation to consult on implementation plans that support robust research designs and plan early data collection." CMS 1115 Guidance at 1 (emphasis added). N.H. App. 59. Moreover, CMS stated that beneficiary surveys "are particularly important data sources for community engagement demonstration evaluations because states must track beneficiaries after they separate from Medicaid to understand employment, income, health status, and coverage transitions over time." N.H. App. 66. Yet CMS did not require the State to prepare a robust pre–launch evaluation design or to conduct beneficiary surveys from the outset, and missed the opportunity to measure crucial early impacts.

VII. Medicaid Expansion's Remarkable Achievements in Providing Medical Assistance to Uninsured Adults Made the Impact of Imposing Work Requirements, Coverage Lock–Outs and Limited Retroactive Eligibility Even More Catastrophic.

A. Expansion in Arkansas and New Hampshire Achieved Dramatic Reductions in Total Uninsured Adults.

Both States posted impressive achievements through implementation of the Medicaid Expansion in 2014. By the end of 2016, Arkansas's expansion reduced the State's uninsured population by fifty percent. *See* Jessica Barnett & Edward Berchick, *Health Insurance Coverage in the United States: 2016 Current Population Reports*, U.S. Census Bureau at 19 (September 2017). Likewise, the number of uninsured adults aged 19 to 64 in New

Hampshire fell from sixteen percent to nine percent. As a result, 55,900 fewer New Hampshire adults were uninsured by 2019. *See* KAISER FAMILY FOUNDATION, *Health Insurance Coverage of Adults 19-64* (2019). These coverage gains meant better healthcare for people across both States, whether poor or not, as communities with high levels of uninsured persons lack critical services even for insured people because of insufficient market conditions essential to financing health care. *See* INSTITUTE OF MEDICINE, *America's Uninsured Crisis: Consequences for Health and Health Care* (2009) at 4.

In addition, extensive evaluation has shown the Medicaid expansion's success in achieving stable coverage and more accessible health care. *See* U.S. DEPT. OF HEALTH & HUMAN SERVS., OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, TRENDS IN THE U.S. UNINSURED POPULATION 2010–2020 (Feb. 11, 2021); Bethany Maylone & Benjamin D. Sommers, *Evidence from the Private Option: The Arkansas Experience*, THE COMMONWEALTH FUND (Feb. 2017); Lara Antonisse *et al.*, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUNDATION (Mar. 2018). Arkansas's expansion reduced uninsured outpatient hospital visits (45.7 percent reduction), emergency room visits (38.8 percent reduction), and hospital admissions (48.7 percent reduction) annually. *See* ARKANSAS CENTER FOR HEALTH IMPROVEMENT, *Arkansas Health Care Independence Program ("Private Option") Final Report* (June 30, 2018) at i.

Petitioners' improper use of § 1115 jeopardized these healthcare coverage and access gains. While more than 18,000 individuals lost coverage during implementation of Arkansas's demonstration, *see* GAO, *Medicaid*

Demonstrations – 2019 Report at 22, it has been estimated that, were nine States with approved compelled work experiments allowed to proceed, an additional 589,000 to 811,000 beneficiaries would lose coverage. Losses of this magnitude reflect between one–quarter and one–third of the 2.5 million people who would become subject to the experimental requirements and are linked only to the experiment's work requirements. Leighton Ku & Erin Brantley, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage*, The Commonwealth Fund (June 21, 2019).

Petitioners were fully aware of what their approvals would trigger, given well–documented similar benefit losses following implementation of SNAP work requirements. *Id.*; *see also* Brantley *et al.*, *As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful*, *supra*. Cognizant of these ravaging effects, Petitioners instructed States to tell people who lose Medicaid coverage due to implementation of these demonstrations to seek care on an uninsured basis at community health centers – a tacit admission of the absurdity of Petitioners' claim that positive results would flow from experiments that imperil Medicaid coverage. *See* Ark. App. 34 (Special Terms & Conditions, ¶ 54.q); N.H. App. 33 (STCs, ¶ 24.u).[4]

4. Community health centers, major Medicaid providers in Arkansas and New Hampshire, treat thousands of uninsured patients. With basic grant funding under Section 330 of the Public Health Service Act, 42 U.S.C. § 254b ("Section 330"), health centers are required to provide care to medically underserved populations regardless of ability to pay. Section 330 grants represent less than twenty percent of health centers' operating budgets, thus they depend heavily on Medicaid to fund the services they provide. *See* Sara Rosenbaum *et al.*, *Community Health Center Financing: The*

B. Extensive Commentary in the Administrative Record Made Clear the Risks Created by Work Requirements and Coverage Restrictions.

Experiments to reduce Medicaid coverage fly in the face of extensive research demonstrating the adverse effects of denying low–income people access to health insurance. *See, e.g.,* KAISER FAMILY FOUNDATION, *Sicker and Poorer: The Consequences of Being Uninsured* (Apr. 2002). Yet Petitioners simply ignored or provided unresponsive answers to extensive public comments presenting well–supported research opposing their assumptions in the SMDL and their demonstration approvals. Repeated comments in the record underscore how these demonstrations would harm beneficiaries while doing little to improve incomes or access to employer insurance or to promote better health outcomes. CMS responded that "[w]e believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment," without citing specific evidence to explain how gaining employment promotes the Medicaid objective to furnish medical assistance. Ark. App. 6; N.H. App. 10. The agency also invoked vague notions of experimentation to justify "community engagement," stating, again without any basis in the record, that "it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote

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Role of Medicaid and Section 330 Grant Funding Explained, KAISER FAMILY FOUNDATION (Mar. 26, 2019). In 2017, health centers served one in four of low–income residents in New Hampshire (91,440 people) and one in six of low–income residents in Arkansas (210,380 people). *See* U.S. DEPT. OF HEALTH & HUMAN SERVS., HEALTH RESOURCES AND SERVICES ADMINISTRATION, BUREAU OF PRIMARY HEALTHCARE, 2017 *Health Center Data* (2018) (Arkansas and New Hampshire tables).

beneficiary independence." Ark. App. 6; *see also* N.H. App. 11.

For instance, the record contains extensive opposition to CMS' "community engagement" policy as an eligibility condition, based on the large body of evidence showing the catastrophic impact of work requirements seen in programs such as cash assistance or TANF. Ark. App. 1269–73, 1276–80, 1301–05, 1330–43; N.H. App. 1949–51, 1480, 2204–18. In addition, an examination of eight State Medicaid work demonstration proposals by the Medicaid and CHIP Payment and Access Commission ("MACPAC"), created to advise Congress on Medicaid services, *see* 42 U.S.C. § 1396, reported that: (1) only one third of people losing TANF benefits found jobs that included employer–sponsored coverage; (2) almost half of the jobs held by Medicaid beneficiaries were at small businesses not required under the ACA to provide health insurance; and (3) 40 percent worked in the agriculture and service industries, known for their low employer–sponsored insurance offer rates. MACPAC, *Work as a Condition of Medicaid Eligibility: Key Take–Aways from TANF* (Oct. 2017); *see also* MaryBeth Musumeci & Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, Kaiser Family Foundation (Aug. 2017); Brantley *et al.*, *As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful*, *supra.* The only experimental question Petitioners conceivably could have tried to answer – so harmful as to take one's breath away – is whether attaching a similar requirement to medical assistance would produce similar catastrophic results. To the many concerns raised in the record, CMS provided a cursory response best summarized

as it "has considered those comments," and embraced uncritically the premise that a work requirement somehow "improves beneficiaries' health" or "promote[s] beneficiary independence." Ark. App. 6; *see also* N.H. App. 12 (CMS' cursory responses to record comments).

CMS was also warned repeatedly with respect to extensive research showing the adverse impact of coverage lock–outs such as the "potential 9–month length of the non–eligibility period" that could result from noncompliance with the community engagement requirement and the two–months reduction of retroactive eligibility in Arkansas's demonstration. Ark. App. 1265–68, 1276–80, 1294–95, 1296–1300, 1306–29; *see also* N.H. App. 1486–93, 2204–22, 2240–50, 2692–2727 (coverage lock out harms) *and* 1479–82, 1486–93, 1952–57, 2200–50 (harms of waiving retroactive coverage).

CMS' unresponsive answer was that "[w]e believe that the overall health benefits to the effected [sic] population through community engagement outweigh the health–risks with respect to those who fail to respond and who fail to seek exemption from the programs [sic] limited requirements." Ark. App. 7; *see also* N.H. App. 11. CMS never explained what health risks or what health benefits it evaluated or what risks–to–benefits analysis it conducted, if any, to reach its decision to approve the community engagement requirement and other changes in these demonstrations. The record contains nothing to show that Petitioners actually considered the multiple public comments that warned these demonstrations could not promote the objectives of Medicaid but would harm thousands of beneficiaries. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126–27 (2016) (acknowledging

a factor only to dismiss it without reason or discussion is no substitute for actually considering it); *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) (noting that "[s]tating that a factor was considered… is not a substitute for considering it" and rejecting as "conclusory" an agency statement that all relevant factors had been considered). The records clearly weighed against approval of the demonstrations at issue.

Petitioners' cavalier approach to approving these demonstrations is self–evident. In violation of the research authority on which its actions rested, CMS turned a blind eye to actual research findings, undertook actions contrary to compelling evidence, implemented a major policy change after the mandatory comment periods had concluded, and failed to weigh the health risks these demonstrations would trigger. *See* 42 U.S.C. §§ 1315(d)(2)(A), (C). In sum, CMS did not meaningfully consider the relevant factors, failed to document a reasoned decision to approve these demonstrations, and offered implausible explanations of the health gains to be had by imposing work requirements or depriving expansion beneficiaries of medical assistance.[5]

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5. The Foundation for Government Accountability ("FGA") submitted an *amicus curiae brief* in these cases lacking references to independent research on the impact of work requirements in Arkansas's Medicaid program. *See* Br. *Amicus Curiae* of the Foundation for Government Accountability in Supp. of Pet'rs (Jan. 26, 2021) at 13–16. Said brief relies mainly on FGA reports, which lack comparison groups, ignore beneficiaries' harm and do not demonstrate that any employment gains were better when work requirements were in effect than when they were not. *See* Brantley *et al.*, *As Biden Administration Begins Unwinding Them, Medicaid Work Experiments Remain Unreasonable, Unnecessary and Harmful*, *supra*.

Moreover, the agency disregarded long–standing research that demonstrates that "[m]ost adult Medicaid beneficiaries work or are limited in their ability to work because of health problems, schooling, child care, or other needs. Many who would lose Medicaid eligibility are working or trying to work, but are unable to comply with the rules because they face major barriers to steady employment or cannot navigate the procedural barriers." Ku & Brantley, *Medicaid Work Requirements*, *supra*. An agency action that "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise" is arbitrary and capricious. *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1982).

C. There is No Realistic Expectation That Those Leaving Medicaid for Work will Find Alternative Sources of Health Insurance.

In approving these two demonstrations, Petitioners asserted, without explaining on what basis, that work requirements create "appropriate" incentives for beneficiaries to gain employment or help individuals and families attain or retain capability for independence or self–care. Ark. App. 3, 6; N.H. App. 6. This assertion rested on two assumptions: (1) part time work at low wages offers employer health benefits and (2) threatening people with the loss of Medicaid will lead them to find the jobs with generous benefits. However, Petitioners cited no tested, supporting evidence. Indeed, CMS permitted both States to abandon the subsidized employer insurance component of the original demonstrations –

one that, it should be noted, had produced exactly forty participants in Arkansas. Ark. App. 3. All evidence points in the opposite direction: part–time, low–wage jobs come without health benefits. Employee health benefits for low–wage workers are uncommon: an average of sixteen percent of poor adults had access to employer–sponsored insurance in the United States in 2016. *See* KAISER FAMILY FOUNDATION, *Health Insurance Coverage of the Total Population* (2016); Sara Rosenbaum *et al.*, *The Trump Administration's Deeply Flawed Assumptions that Underlie its Medicaid Compelled Work Experiments*, *supra*. These demonstrations were not grounded on evidence or reasonable theory, rendering their approval contrary to the express experimental authority in § 1115.

Moreover, there is no evidence to suggest that depriving people of Medicaid will lead to greater levels of employer–sponsored insurance. For the people who lose Medicaid because they fail to satisfy work and "community engagement" requirements, a return to persistently uninsured status will be the norm. Unsurprisingly, in addressing the Arkansas demonstration at issue in this appeal, MACPAC noted that "[w]ork and community engagement waivers represent a significant new policy direction for the Medicaid program," expressed its concern that "there was not an approved evaluation design in place at the time of implementation," and "urge[d] HHS to pause disenrollments under the waiver." *See* Letter from Penny Thompson, MACPAC Chair, to Alex Azar II, Secretary of HHS at 2, 4 (Nov. 8, 2018). Indeed, the independent research into the first–year consequences of the Arkansas experiment found no significant change in employer coverage. *See* Sommers *et al.* (Sept. 2020), *supra*.

Petitioners' actions were the antithesis of a carefully designed experiment. These demonstrations amounted to a naked move to fundamentally alter Medicaid eligibility policy nationally. Petitioners approved similar demonstrations for eleven other States (Arizona, Georgia, Indiana, Michigan, Nebraska, Ohio, South Carolina, Utah and Wisconsin – plus Kentucky and Maine, which terminated their projects), of which eight still lack an approved evaluation design. *See* CMS, STATE WAIVERS LIST (last visited Feb. 12, 2021). Eight additional States (Alabama, Idaho, Mississippi, Montana, North Carolina, Oklahoma, South Dakota and Tennessee) applied and are pending approval. Federal Pet'rs' Br. at 15, n.6. There is no authority to place nearly half the country under demonstrations that extend no consideration to beneficiary impact, respond to flawed assumptions, and lack hypothesis testing and objective evaluation. Petitioners do not have this sweeping discretion under any plausible reading of the law.

CONCLUSION

For the foregoing, this Court should affirm the decisions of the Court of Appeals.

February 25, 2021

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APPENDIX

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